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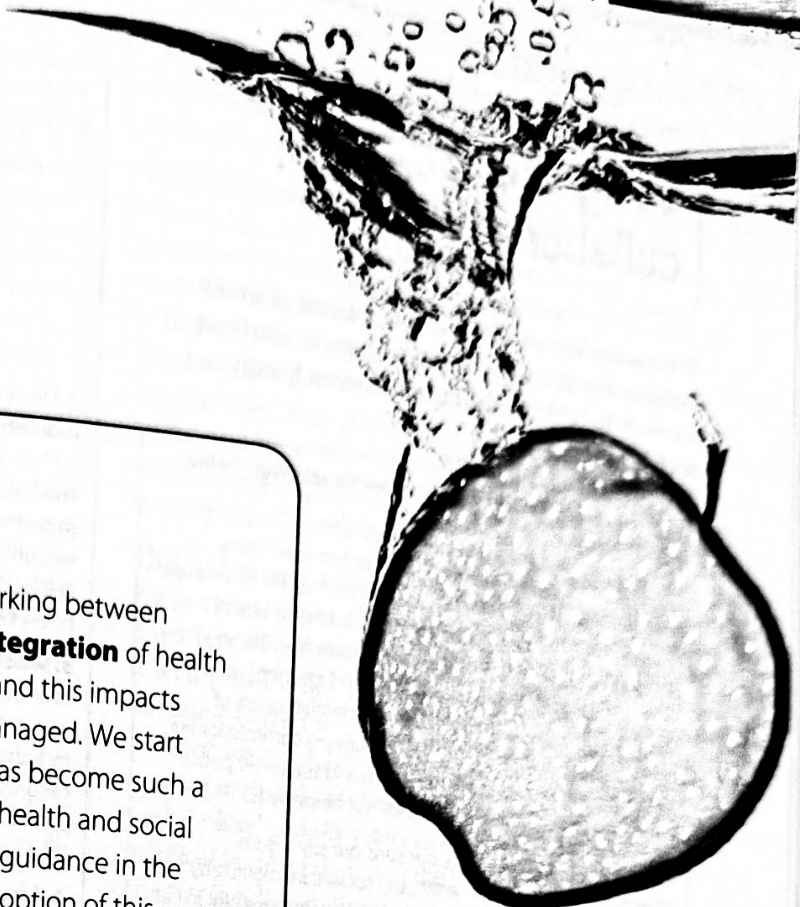
CHAPTER 6

Collaborative working



Introduction

The focus of this chapter is collaborative working between organisations, teams and individuals. The **integration** of health and social care is a clear theme at this time and this impacts on how organisations are structured and managed. We start by looking at how 'working in partnership' has become such a strong and recurrent theme in all aspects of health and social care over many years. We identify key policy guidance in the area and examine the reasons behind the adoption of this philosophy.

The chapter considers some of the various overlapping terminology used and asks whether, in essence, the same principle is at stake whatever the language. We follow this by taking a detailed look at the kinds of problems that occur when agencies do not work together effectively. Reflecting on and understanding these difficulties leads us on to an in-depth discussion of what lessons we can learn from research in this area. We then focus down to 'worker level' in more detail. We investigate the various reasons why, despite the strong messages from above, working in collaboration doesn't always work 'on the ground'.

To conclude the chapter there is a detailed section which considers both useful methods and the specific skills needed to ensure that the policies of working collaboratively can be put more meaningfully into practice.

This chapter addresses the following areas:

- Why work collaboratively?
- Issues
- Why collaborative working doesn't take place
- Effective collaboration

After reading this chapter it is hoped that you will be able to:

1. understand the reasons why collaborative working has been placed on top of the care agenda in recent years
2. be aware of the various reasons why collaborative working between agencies has not always happened
3. appreciate the difficulties that can occur when effective collaborative working does not take place
4. examine ways for workers to facilitate successful collaborative working.

Why work collaboratively?

Within the field of social care, the theme of working collaboratively has a long history, particularly when it comes to bridging the divide between health and social care.

Commissioning Framework for Health and Well-being (Department of Health, 2007)

Commissioners do not necessarily share between them information that could help improve outcomes for individuals or the population as a whole, and there is often a lack of understanding about what is legally permissible. We need to work towards an environment of trust and partnership, which gives people reassurance that the confidential nature of information will be respected while enabling commissioners to make appropriate use of it for them and the wider public interest within existing legal and ethical constraints.

The White Paper ***Our health, our care, our say*** has set objectives for integrated health and social care records by 2010 and, while this is a challenging target, some useful initial work has been done. NHS Connecting for Health has established an electronic social care record board (ESCRB) with responsibility for overseeing national implementation of the electronic social care record, ensuring consistency of its implementation by local authorities with social services responsibilities and integration with other information systems.

The effective sharing of appropriate information about individuals is crucial to more integrated **commissioning** and care, but it is also a complex challenge. The role of the Patient Information Advisory Group and local Caldicott Guardians are important in this context and the National Information Governance Board will strengthen arrangements. A scoping study of closer integration between health and social care systems, covering all client groups, is due to be completed by May 2007. This will address issues about information-sharing between health and social care and will take account of the recently published NHS Care Record Guarantee, which emphasises the rights of individuals to consent to information about them being shared. This study is also looking into how the technical architecture recommended in the SAP project can be implemented.

'The White Paper ***Our health, our care, our say****, promised to help people stay healthy and independent, to give people choice in their care services, to deliver services closer to home and to tackle inequalities. This framework is about action, with a particular focus on partnership. It is for everyone who can contribute to promoting physical and mental health and well-being, including the business community, government regional offices and the third sector.'*

This framework identifies eight steps to more effective commissioning:

1. Putting people at the centre of commissioning
This involves giving people greater choice and control over services and treatments (including self-care), and access to good information and advice to support these choices. Mechanisms will be developed to help the public get involved in shaping these services, with advocacy to support groups who find it hard to express views.

2. Understanding the needs of populations and individuals
Joint strategic needs assessment by councils, Primary Care Trusts (PCTs) and practice-based commissioners will help them to better understand the needs of individuals, by using recognised assessment and care planning processes appropriately, and mitigating risks to the health and well-being of individuals.

3. Sharing and using information more effectively
In order to make effective decisions for individuals and groups, we need to use and share information in an effective way. This includes clarifying what information can be shared under what circumstances, joining up the IT systems of frontline practitioners and encouraging individuals and communities to be co-producers of information.

4. Assuring high-quality providers for all services
Commissioners should develop effective, strong partnerships with providers and engage them in needs assessments. Procurement should be transparent and fair. Commissioning will be focused on outcomes, leading to more innovative provision, tailored to the needs of individuals and supplied by a wider range of providers.

5. Recognising the interdependence between work, health and well-being
Commissioners can facilitate collaborative approaches with businesses to improve advice and support for individuals. Additionally, all providers of NHS care will be incentivised to support and promote the health and well-being of their employees.

6. Developing incentives for commissioning for health and well-being
Bringing together local partners using Local Area Agreements will help to promote health, well-being and independence, by using contracts, pooling budgets and using the flexibilities of direct payments and practice-based commissioning.

7. Making it happen – local accountability
The Department of Health and the Department for Communities and Local Government will develop a single health and social care vision and outcomes framework, including a set of outcomes metrics aligned with the framework.

8. Making it happen – capability and leadership
The Department of Health and other national stakeholders will provide support to all local commissioners to address their capability gaps, where these national organisations can add real value.

ACTIVITY

1 What do you understand by the phrase 'commissioning' and does your own organisation get involved in any aspects of the commissioning process?
2 What do you think are key factors in the way that agencies work together?
3 What model of partnership does your organisation work to and what is your role in supporting this?

Given the diversity of welfare services in terms of different professions, different departments, different training, changing roles and functions, it is little wonder that, despite the best efforts of many, effective collaboration between different agencies has been hard to achieve. Much of the time different agencies have been pulling away from each other rather than pulling together. The government made this blunt observation in its 1998 document *Modernising Social Services*.

> Sometimes various agencies put more effort into arguing with one another than into looking after people in need.

Next, we will look at how, since the late 1990s, New Labour governments have been determined to ensure 'joined up' government and 'joined up' ways of working and have made certain policy statements to back up the need for agencies to work in partnership. However, first you should be aware of where your own workplace fits into this agenda.

Collaboration: definitions and debates

A theme throughout this whole book is the need to be mindful of the language we use. We need to ensure clarity when we are communicating with others but we have seen that different words convey different nuances of meaning to different people. The temptation in this chapter is to talk in terms of 'other professionals'. We prefer not to use this term but instead use the more general term 'worker' because it is less exclusive and more accurately describes the full range of workers who get involved with our clients. For the purpose of this chapter, 'worker' refers not only to paid workers but also to unpaid workers, such as an advocate or volunteer.

Using phrases to clients such as 'we've had a meeting of professionals' may sound impressive but it is potentially belittling and disempowering to them and their families. It also calls into question who exactly is a professional anyway. There is too much 'us' and 'them' in this phrase. Such use of the word 'professional' may possibly exacerbate tensions between, say, a senior residential care worker and an occupational therapist – both of whom play an equally valuable role but have had different training.

This is obviously quite a subjective area. However, for the purposes of this chapter the chosen term to denote anyone with a formal role with the client is 'worker'. It is currently quite fashionable in social care discourse to refer to 'stakeholders' in the context of working together. Use of this word will mainly be avoided in this chapter for the reason that 'stakeholder' usually refers to both formal and informal involvement, and the main focus of the chapter is collaborative working between formal workers – that is, workers who work for some form of organisation – not families, neighbours or friends.

Mostly, the organisations that those other workers work for will be referred to as 'agencies'. This is an unfamiliar term for some people and can be difficult to get to grips with. Clients can mistake what you mean because they may associate the term with other types of agencies they are more familiar with, such as travel agencies or estate agencies. The term also has its limitations when referring to where, say, GPs or district nurses work. We might prefer to use the term surgery, practice or even primary healthcare team. However, when we talk about 'inter-agency' collaboration between, say, health and social care or social care and housing, we mean all those workers who work in that area of service provision.

What do we mean by collaborative working?

Literature in this area abounds with different words and phrases for what is essentially the same thing. We could talk about collaborative working, joint working, co-operation, working in partnership, working together, inter-agency working, multi-disciplinary working, networking, coalition, integrated working,

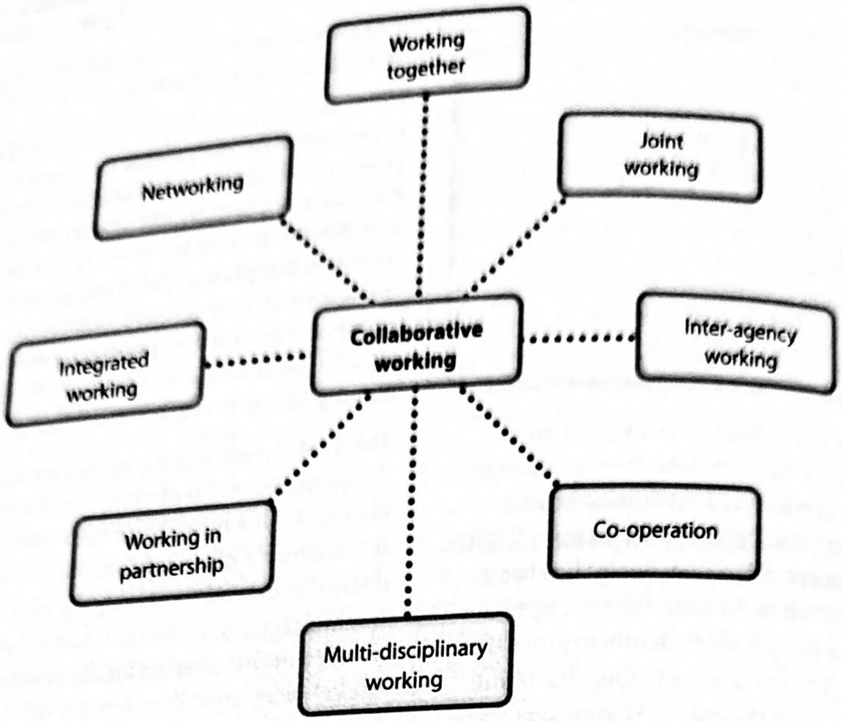


Figure 6.1 Types of collaborative working

or even consultation. Each of these terms could be said to have its own particular shade of meaning and, in certain contexts, there may be significant differences. Nevertheless, in the context of this chapter, we are essentially using the terms interchangeably. Our basic idea is that they are all used to refer to the notion of collective actions by individuals or their organisations which produce more benefit for clients than each could accomplish as an individual player.

REFLECT

What would your favourite term be for workers working together to promote the best interests of their service users? What term do you use where you work?

If anything, collaborative working has been chosen mainly because this is a book primarily written for frontline workers. Other terms like joint working or working in partnership are often more associated – at least in some people's minds – with working together at a higher organisational level, such as joint investment, joint commissioning, pooling of budgets and so on. We will, however, return later to discuss the different levels on which collaborative working can take place even between frontline workers.

What guidance have you had about the need to work collaboratively? You will need to locate your own organisation's mission statement or statement of purpose and find out what it says about working collaboratively. What about other manuals, practice guidance or operating instructions? Read them through – especially the introductory sections. What evidence can you find that there are moves to ensure more effective collaborative working?

It would be surprising if your research did not inform you that the requirement to work collaboratively is embedded in all kinds of policy documents. As indicated earlier, *Modernising Social Services* is the original New Labour blueprint for working collaboratively. However, before that, the need for health and local authorities to prepare Joint Investment Plans had already been established resulting from the *Better Services for Vulnerable People* guidance issued in 1997. In 1998, two significant developments took place. The government set up the Health and Social Care Joint Unit, whose job it is to develop policy on joint working between health and

Policy guidance

The new Local Performance Framework will be of fundamental importance in supporting this to happen. Primary Care Trusts and Local Authorities are working in the Local Strategic Partnerships (LSPs) to agree new Joint Strategic Needs Assessments. Joint Strategic Needs Assessments (JSNAs) will provide the foundation for health and well-being outcomes within each new Local Area Agreement (LAA). Our ambitions for modernising social care sit entirely within this Framework.

The importance of this holistic approach is recognised and underpinned by *'Putting People First: A shared vision and commitment to the transformation of Adult Social Care'*, a concordat that establishes a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator. It sets out the shared aims and values, which will guide the transformation of adult social care.

Across government, the shared ambition is to meet the aspiration to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity. Local priority setting will be focused on meeting local needs and playing a leading role.

Our health, our care, our say: a new direction for community services

Department of Health (2006)

social services. It also published a discussion document called *Partnership in Action*. In the foreword Ministers for Health explain:

> All too often when people have complex needs spanning both health and social care, good quality services are sacrificed for sterile arguments about boundaries. When this happens people … and those who care for them, find themselves in the no-man's land between health and social care services. This is not what people want or need. It places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayer's money – it is unacceptable.

Although the document goes on to say that 'major structural change is not the answer', subsequent legislation has paved the way for far-reaching structural and organisational change. For example, the Health Act 1999 gave both health and social care agencies powers to pool budgets and delegate functions to enable provision and lead commissioning. This impacted more at management level. The Health and Social Care Act 2001 introduced changes that would affect workers at all levels. This Act created a new body – the 'Care Trust'. The aim of this radical step was to achieve integration of health and social services for vulnerable people. Instead of persisting with the line that two separate agencies must work more closely together, the creation of Care Trusts meant the dissolving of existing organisational boundaries and creating new integrated organisations. To some extent, the way had been paved by the earlier phasing in of Mental Health Trusts which operate on a similar integrated principle. However, the tradition of multi-disciplinary working through the Community Mental Health Team made this change less of a culture shock.

It should not be assumed that the concept of partnership working is simply about health and social care, important as these two elements are. The National Service Framework for Older People, for example, set up Local Strategic Partnerships, whose role is to 'bring together the public, private, voluntary and community sectors' into a single 'overarching framework'. The document assumes that the various standards it sets can only be met by all relevant services working together. Therefore, issues of housing, transport and a range of other services have to be co-ordinated at a strategic level.

As far as actual working practices at the frontline level are concerned, collaborative working has been signalled in just about every policy document concerned with health and social care. For example, *Valuing People*, the government's major policy document for people with learning disabilities, under the heading 'Integrated Professional Working', makes this statement:

> (Learning Disability) Partnership boards should review the role and function of community learning disability teams in order to ensure that:

> all professional staff become a resource for the local implementation of the White Paper and to help achieve social inclusion for people with learning disabilities
>
> organisational structures encourage and promote inclusive working with staff from the fields of housing, education, primary care, employment and leisure.
>
> (Department of Health, 2001, page 110)

It is clear that the principles of *Valuing People* can only be achieved if staff work collaboratively.

Standard 2 of the National Service Framework for Older People is about 'Person-centred care'. Its stated aim is that:

> NHS and social care services treat older people as individuals and enable them to make choices about their care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.
>
> (Department of Health, 2001, page 23)

CASE STUDY

Integrating services

Barnsley is pursuing integration via its commissioning activity. Commissioning and provider functions are formally separated, there are pooled health and social care budgets, and services are commissioned from the provider arm. Barnsley's focus is on the practical implementation of individual budgets for routine care, rather than selection of an off-the shelf governance structure.

Questions

1 What is your local authority's approach to the organisation of health and social care and the commissioning process?
2 To what extent does your local authority encourage independent providers of health and social care?
3 What benefits does the commissioning process have to the organisation and delivery of care for local people?

Both managers and 'professionals' are told that they must 'provide co-ordinated and integrated service responses'. We have to remember that an important reason that the National Service Framework was introduced in the first place was to eradicate unnecessary delay and duplication of effort – this implies a commitment to working collaboratively. In a similar vein, the National Service Framework for Mental Health embodies the same principles. It states that people with mental health problems can expect that services will 'be well co-ordinated between all staff and agencies'.

Therefore, we can see quite clearly that in all areas of care the need to work collaboratively is clearly stated in official documentation. Over and above this, we have seen that in the field of health and social care, the government has been prepared to make radical changes to organisations to try to ensure that the old barriers to collaborative working practices might be dismantled.

Department of Health Private Finance Initiative: Criteria for bids approval

There are four Department of Health criteria for adult social care PFI. These are consistent with the White Paper *Our Health, Our Care, Our Say*. The emphasis is on using capital investment to integrate people rather than isolate them; and to provide them with choices and opportunities for getting better and getting back to independent living where possible.

One of the criteria is that of joint planning and joint working:

> We expect projects to demonstrate close cooperation and joint working between health and social care in a way that supports social inclusion and is relevant to the client group needs that are being addressed.

The case for collaboration

We have seen how successive governments have set out the case for working collaboratively. This wisdom is handed down from 'on high'. There is no reason to accept this view uncritically. Many writers have commented on the dearth of hard evidence that supports this view. In fact, some have challenged the idea that collaborative working is inherently a good thing. Concerns have been raised about blurred accountability as well as questioning whether claims of comprehensiveness and seamlessness are justified (Leathard (1994), Loxley (1997), Hudson (2000)).

Therefore, we need to proceed positively but with a degree of healthy scepticism. If we reflect on our own experiences in social care, these can almost certainly provide many reasons to work collaboratively. We should ask ourselves what working in care would be like if we were compelled to work completely on our own. How successful or effective would we be if we were denied the advice, knowledge, opinion or any other type of input from other workers? How are our clients benefiting from workers working in isolation from each other?

It is perfectly possible that some workers do not think there would be any problems. They presumably enjoy the freedom from the interference of others, content in the knowledge that they are capable of sorting out all aspects of their client's care on their own. Sometimes we work with people assuming that we are the only worker who matters in their lives. This raises a key question – are we always aware of who else is involved in our service users' lives and what they do?

REFLECT

1 Think about your own work. With the clients who you work with, make a list of all the other workers, of any description, who have in some way had some input or influence in those clients' lives. Remember you don't have to see or speak with these workers personally; communication could be through referral or report, letter, fax or email. You may even be aware of their existence but have never communicated with them.
2 Group these other workers under main headings such as health, education, social care, housing, benefits, other.
3 Compare your list with someone else from another area of work, if possible. Either on your own or with another, go through the workers under each heading and identify:
   a Who do you have most contact with?
   b Who do you enjoy the best working relationships with?
   c Who the least?
   d Who have you got on your 'other' list? Are they from statutory agencies such as the police, voluntary organisations or private agencies such service providers?

Completing this exercise should have brought out how many different workers may be involved with our clients. Some clients have many involvements, for others you may be the only worker. The exercise probably showed we work more closely and more frequently with some workers than others. There also might have been other observations, such as frequent contact with certain workers doesn't always mean that you have a good working relationship with them. You may even have started wondering more about what exactly it is that those other workers do! The basic premise of this chapter is that client care improves if there are good working relationships between all workers involved. Have any of your thoughts or discussions so far suggested otherwise?

Partnerships in practice

So far, we have established that, ordinarily in social care, several workers from different agencies work with vulnerable people. We have also seen that over a long period successive governments have urged that to promote better, person-centred care the various agencies – and the disciplines within them – need to work a lot more closely together. Government has also backed this up with key policy changes.

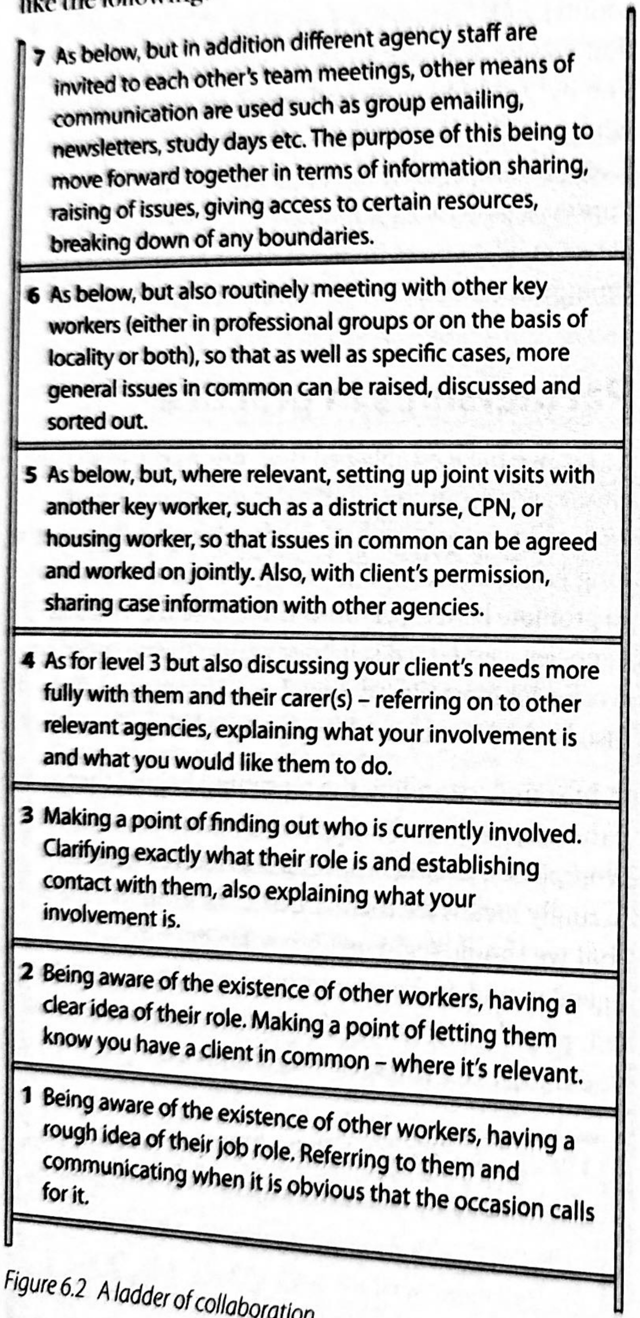
Whilst understanding the reasoning behind these exhortations, frontline workers, in their various workplaces, should be asking themselves what it actually means for them. Does it, for example, mean that we should team up with colleagues from other agencies and approach our work as a kind of double act, a kind of care version of Dalziel and Pascoe? It is one thing to extol the virtues of working

REFLECT

When you see statements urging you to work more in partnership, work collaboratively or work in a 'multi-disciplinary' fashion, what does it actually conjure up in your mind that you should be doing? Write down how you understand this term.

collaboratively, it is another thing to put this into meaning for people.

If you had been undertaking that activity 'collaboratively' with another worker, it would be interesting to share your views and compare your different responses. This in itself would be an example of one form of collaboration. We are sure you have found that there are many meanings that can be attached to this whole area. If we were to arrange the various ways of what working collaboratively could mean in some sort of order or hierarchy, it might look like the following.



7 As below, but in addition different agency staff are invited to each other's team meetings, other means of communication are used such as group emailing, newsletters, study days etc. The purpose of this being to move forward together in terms of information sharing, raising of issues, giving access to certain resources, breaking down of any boundaries.

6 As below, but also routinely meeting with other key workers (either in professional groups or on the basis of locality or both), so that as well as specific cases, more general issues in common can be raised, discussed and sorted out.

5 As below, but, where relevant, setting up joint visits with another key worker, such as a district nurse, CPN, or housing worker, so that issues in common can be agreed and worked on jointly. Also, with client's permission, sharing case information with other agencies.

4 As for level 3 but also discussing your client's needs more fully with them and their carer(s) – referring on to other relevant agencies, explaining what your involvement is and what you would like them to do.

3 Making a point of finding out who is currently involved. Clarifying exactly what their role is and establishing contact with them, also explaining what your involvement is.

2 Being aware of the existence of other workers, having a clear idea of their role. Making a point of letting them know you have a client in common – where it's relevant.

1 Being aware of the existence of other workers, having a rough idea of their job role. Referring to them and communicating when it is obvious that the occasion calls for it.

Figure 6.2 A ladder of collaboration

The hierarchy can be drawn in many different ways with plenty of other stages built in. It is not definitive by any means. However, the point we are trying to make is that there is a spectrum where at the least collaborative end a worker will be mainly independent, reacting to the roles of others only where it is clearly obvious and usually just on the specifics of one case. At the other end, the approach is more proactive and thinking outside of the details of a particular case; here the worker is consciously seeing themselves as part of a wider network.

CASE STUDY

Working together

Gavin Chadwick is a 29-year-old man with cerebral palsy who is keen on all types of sports. He lives on his own and has a 24-hour carer paid for by social services. He has read about Direct Payments and would like to take this further.

You go and see Gavin to discuss things in more detail. It becomes apparent that there are other issues in his life. He is bored on his own with nothing to do, his main contact being with his family. He is also fed up with the bland diet that 'the medics' originally recommended he follow. He doesn't say so but you think he is depressed. His car is off the road and he is having problems with the Motability scheme so he can't get it replaced to go anywhere.

You are not very experienced in how Direct Payments work. You are also put off by the paperwork.

Questions

1 From the details you have, what would be the least collaborative working response to Gavin?

2 How might working more collaboratively benefit not only Gavin, but other people in similar positions and other workers as well? Give specific suggestions and explain your reasoning.

ACTIVITY

Identify recent government initiatives that urge closer working between health and social care.

Investigate your own organisation's approach to working with other organisations.

Issues

Although our focus in this chapter is primarily adult social care, there are nevertheless key lessons that can be learnt from the reports published in respect of child abuse tragedies.

We are probably all too aware of the number of inquests and enquiries that have been held when child abuse tragedies have occurred. One of the most high profile ones was the investigation into the death of Maria Colwell in 1973. The findings showed that a major contributory factor in Maria Colwell's death was the lack of inter-professional co-operation. On the back of the Report major changes were made to the UK's child protection system, and inter-agency working was built into the system. However, the new system could not prevent the death of Jasmine Beckford in 1985 and the huge problems in Cleveland in 1987 when the authorities overreacted in response to concerns about widespread sexual abuse. A new major set of guidelines was produced in 1988 called *Working Together* which was followed by the Children Act 1989. In 1995, the Department of Health published *Child Protection: Messages from Research*.

Unfortunately, the various initiatives to improve inter-agency working have not been able to prevent the deaths of children known to the authorities, the most high profile case in recent years being that of Victoria Climbie. Lord Laming produced the findings from his inquiry in 2003 and the progress against these has been regularly reviewed. He stated in 2007 his dismay at the lack of change in what he viewed as manageable actions.

REFLECT

Investigate the findings from the Laming Inquiry 2003 and consider to what extent your own organisation has adopted the principles that it suggests.

There is one striking feature of the vast majority of the inquiries that have been reported which stands out above all others – it is each committee's conclusion that inter-agency communication was flawed. Typically, there were crucial mistakes identified where agencies did not pass on or share information with each other. These reports show that tragedies occur not only when a single piece of information of major importance is not passed on properly, but when the passing of any information doesn't take place – however seemingly insignificant; this prevents workers in various agencies from building up a full picture of what is going on. The same 'small' thing happening many times is as important to know about as a 'big' thing happening once. This was evidently a problem in child protection, but can equally be a

CASE STUDY

The need for information to be passed on

Arthur Robins is an 80-year-old diabetic who also has Alzheimer's disease. He has domiciliary care at home but his 81-year-old wife Ada tends to keep an overall eye on him. Ada is rushed into hospital with suspected angina. The request is made by the GP to social services that Mr Robins must be found emergency respite because he has Alzheimer's and cannot be left on his own. The GP also says that with Mr Robins there is often a risk of hypoglycaemia.

Mr Robins is quickly assessed and taken to a nearby residential home for a two week stay while his wife undergoes investigations and treatment. The day after his admission Mr Robins becomes quite ill. Social services are also telephoned several times by his daughter wanting to know why he had been admitted to a home when her own daughter would have been able to stay in the house for at least a week. Both the district nurses and the daughter make a strong complaint that the home were not informed about Mr Robins' diabetes, saying that he could have been kept at home given the amount of distress it has caused him.

Questions

Think over these details.

1 What information is not passed on and why?
2 Why do you think this is?
3 How do you think the whole situation could have been improved – paying particular attention to the communication of information between different workers?

problem in work with vulnerable adults. The outcomes might not always have such seriously tragic consequences but could be very distressing or harmful nevertheless. The significance of one 'small' piece of information may not be appreciated until it has been collated with other 'small' pieces of information.

The pooling and sharing of case information is vital if collaborative working is going to take place effectively. There are reasons why this doesn't always take place as we will examine in more detail later on in the chapter. Failure to share information effectively can often lead to problems. However, equally important is the need to make sure that the other worker or agency understands the significance of any information given to them.

In an emergency vital information may not be passed on to all who need it

Key lessons to be learnt from the kind of case described above include these.

- Time taken to build up more information about Mr Robins' situation would have led to better decision-making. The impulse to do something quickly should be avoided.
- Workers from social services did not feel able to further interrogate the opinion of the GP. Is this a sign of professional power imbalance? In any event, the GP and social services have not collaborated very well.
- Information about Mr Robins' health and how best to manage it was not fully made clear.
- Too much is taken for granted and insufficiently clarified to all concerned.
- Information about Mr Robins' family network was not fully investigated and shared.
- The views of Mr Robins, his wife and his regular carers don't seem to have been explored in any great detail.

There are other points that you could make about this kind of case but it shows the peril of making decisions and embarking on courses of action with too little information, and the problem of incorrectly using information that is known. The case study suggests some 'remoteness' between the workers involved. It does not seem that they have developed any real trust or mutual understanding – as a result, client care has suffered badly. If care is increasingly about the assessment and management of risk, then not only must this process be informed by an adequate flow of information between concerned parties but workers should make others clearly aware about what they consider the risk factors to be. As discussed in Chapter 7 on assessment, for all kinds of reasons not everyone has the same perception of risk – it should not be taken for granted that if, say, you use the term 'hypoglycaemia' in a discussion the other will know what the significance is. On the other hand, the person hearing the term 'hypoglycaemia' needs to clarify its significance and what to do about it.

What lessons can be learned?

How might the different workers react to the situation in the case study? Here is one scenario:

- The GP becomes exasperated by what has happened and makes this clear in discussion with their colleagues at the medical practice. They regret the lack of basic health care knowledge possessed by social care staff.
- The social services workers lament the autocratic style of the GP blaming them for passing on partial information.
- The residential home staff feel a mixture of guilt and anger about the way Mr Robins' admission to their home was managed. They have been

presented with a man who they weren't able to look after properly. They blame both the GP and the social services.

It would be nice to think that such defensive and blaming reactions would not take place. However, we all know that in reality they often do. We would suggest that the whole process could have gone better, and there would have been less cause for recrimination, if all parties concerned knew each others' ways of working and were familiar with and trusted each other *before* the incident takes place. A key lesson is that it is hard to work effectively with people who you don't know or are not sure about.

Therefore, while it is not hard to demonstrate that client care suffers when workers don't work collaboratively, it needs to be recognised that another more insidious problem is that each failure, like the one seen in the case study, can quite easily lead to a more entrenched view of one set of workers about another. Less trust and more suspicion are likely to further inhibit the good working relations needed to work collaboratively.

REFLECT

Reflect on your own work. Think about occasions where collaborative working did not take place effectively. What sorts of problems emerged? Who were they a problem for and why?

CASE STUDY

Confusion

Danny Miles is 25 and has Down's Syndrome; his learning disability is categorised as mild to moderate. He lives in a group home run by a housing association and staffed by an independent care agency. He has a keyworker at the group home. He also has a care manager employed by the local Learning Disability Partnership. Five days a week, he attends a life skills course at his local FE college. There he has a personal tutor, Mike. Danny's parents live about 15 miles away and see him at least once a month.

At lunch time, Danny has got into the habit of occasionally augmenting his lunch money by leaving the college, walking into town and telling passers-by that he has lost his lunch money. Sometimes he goes to the nearby pub and offers to buy drinks for others at the bar. Mike knows from first-hand experience that Danny has a very low tolerance of alcohol. The local pub has an arrangement with Mike that should they see this happening they will let him know. Mike then goes over informally to the pub to collect Danny. He reminds him that there are risks and 'morality' problems with what he's doing. The behaviour then usually stops for a while.

The college tutor has never passed this information on to anybody outside the college. This is mainly because he doesn't know who exactly is involved with Danny and also because he regards it as 'college business'. In any event, he thinks that the existing arrangement works fine. Every year Mike is invited to a case review held at the group home. Mike couldn't get to the last one because he was teaching.

Unbeknown to Mike, Danny also frequents the pub at the weekend when he goes with a small group of residents under the supervision of a group home worker. They mainly go for bar games and only order soft drinks.

On one occasion, however, a new member of the bar staff serves Danny and his new 'friends' at lunch time. He then continues serving other customers. After half an hour Danny is drunk and involved in a brawl with two other men. Danny ends up being violently sick. The member of staff calls the police who, in turn, call the social services. Danny's care manager is baffled by what's happened and takes Danny round to his GP for a medical examination. Eventually, after many phone calls the situation is sorted out and Danny is taken home. The following day, Danny's parents insist on talking to the group home manager – wanting to know how such an incident could take place.

Questions

1 Who is responsible for this episode – are Danny's parents talking to the right person?

2 If you were the care manager, how would you ensure that similar misunderstandings did not occur?

Your reflections might have thrown up several different kinds of problem. The next one we shall look at is confusion.

It would seem that a key factor in the scenario above was not only the lack of information passed on, or the failure to do a proper risk assessment, but the general confusion about who has responsibility for Danny's welfare, and what that responsibility entails. As a result, Danny found himself in a very vulnerable situation. It would be tempting to simply blame Mike, the college tutor, but it is more than that, it's more of a system failure. The overall network around Danny had broken down – or, as it appears, never been properly established. Working collaboratively would have entailed interested parties meeting, talking through what Danny is like and what he likes to do, the risks involved and, more importantly, discussing how to manage the situation collectively. This could have forestalled a very unfortunate incident.

Duplication of effort

The final problem we are going to focus on when people don't work collectively is that of duplication of effort. The introduction of the Single Assessment Process recognised that vulnerable adults usually have several social and healthcare workers attending to them. Also, when more than one worker becomes involved with an individual, that person can often face several assessments – all asking for a lot of the same information. This is a waste of time for all concerned and is potentially both tiring and irritating for the person concerned.

The Single Assessment Process may have gone some way in cutting down on duplication at the assessment stage, although this has yet to be fully researched. However, the initial assessment is only one area where, because of unco-ordinated inputs, duplication of effort can take place. It doesn't include all areas of involvement – just those from the statutory health and social fields. Unnecessary duplication can take place at every stage of care involvement. The result is always wasteful but often there are other negative consequences – confusion and alarm for example. If we go back to Danny's case, if all of the people involved with him had decided, for one reason or another, to contact his parents, the parents could have easily felt overwhelmed and much more concerned.

Information gathering and contact with clients and their families are two areas identified where duplication of effort takes place.

REFLECT

From your own practice, identify areas of work or procedure that are often unnecessarily duplicated by more than one worker. Consider these questions.

1. What are these areas?
2. How much is the duplication you have identified to do with individual work practices and how much is a consequence of organisational procedures?
3. In both cases, how could such duplications be avoided?

On the level of the individual worker, we would suggest that there are reasons why work is duplicated. Firstly, it may be that one worker isn't aware that another is involved. Secondly, they might not trust the other workers to do the task properly. Thirdly, agency working practices may not permit the sharing of information. In each case, the development of better collaborative working relationships could help deal with each of these problems – to the benefit of all concerned. There are clearly limits to what extent frontline workers can change agency procedures, but that doesn't mean there aren't many areas where improvements could be made.

KNOWLEDGE CHECK

1. Identify three major problems that can occur when workers don't work together effectively.
2. Explain why, sometimes, simply passing on information to another agency isn't always going to promote client care.
3. How would you put the vicious circle of suspicion and the virtuous circle of trust in your own words?
4. What types of confusion might occur in a case where several workers are involved?
5. Describe three reasons why work with clients can be unnecessarily duplicated.

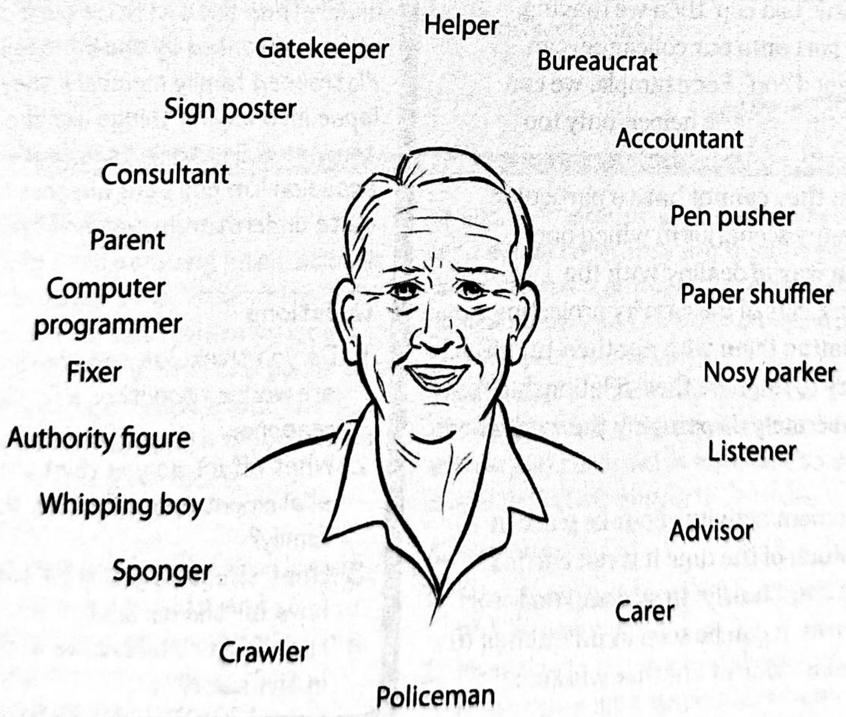
Why collaborative working doesn't take place

Several studies have investigated the many barriers to effective collaboration that exist. Nearly all of them point to factors that run much deeper than the practices of individual workers – such as different organisational cultures or professional philosophies. Each of these factors will be examined in more detail later on. However, because this is a text written primarily with frontline workers in mind, we acknowledge that at day-to-day level there are obvious limitations as to how much the individual worker can influence organisational structures or cultures. Nevertheless, this should not be an excuse to shrug our shoulders, fail to take responsibility and put it down to being a 'management thing'.

We would argue that in many cases, collaborative working doesn't succeed because of a combination of factors – involving organisational, cultural, philosophical and personal factors. There is usually an interrelationship between one or more of these factors. The justification for saying this is that often, even when relationships are poor between agencies, there are some workers who still manage to establish good working relationships with others despite the barriers they face. Conversely, there are situations where two agencies might be committed to joint working. They could have many systems in place to ensure that this happens but there are still problems at the interpersonal level. Consequently, the situation is a complex one and needs to be tackled on many fronts and at many levels.

REFLECT

1 In no particular order, write down all the various ways you see your job role.



2 From doing the exercise, how clear are you about what exactly your job role is? Are there conflicting parts to it? Are there any ambiguous parts to it – i.e. aspects that you're not really sure about because they could be seen in different ways?

3 Next, sort out those aspects of your job that you like to do and that you're proud of, those you're neutral about and those you actually dislike doing and that make you feel bad about yourself.

Personal factors

As will be discussed in Chapter 7 we all bring our own personalities, backgrounds and values to our work – this is called our personal context. We also argued that we should try to develop a degree of self-awareness about our personal context in order to ensure that it didn't interfere with the goal of being focused on our clients' needs. It is worth considering this as we seek to explore why sometimes problems emerge when we try to work collaboratively.

Clearly, depending on our jobs and personalities, we will all have different responses. It would be odd, however, if there were no ambiguities, conflicts or aspects of our role with which we were uncomfortable. There are several 'faces' we need to present to our clients and their carers. There are several aspects of our job roles with which we feel more comfortable than others. Sometimes, it is very tempting to try to pass the more difficult or uncomfortable sides of our role onto others. That way we have less role conflict, less ambiguity, less inner tension and more peace of mind. When working with other workers we can sometimes fall into this trap. If we can make them the 'bad cop' then we (having shuffled the difficult part onto our colleague) can relax in the role of 'good cop'. For example, we can present ourselves as the genuine helper, only too willing to help, whilst the other is the bureaucrat telling the client that they cannot have a particular service. There are many scenarios in which one worker tries to find a way of dealing with the perceived negative aspects of the case by projecting them onto or associating them with another. In this way, workers can try to improve their relationship with a client by deliberately disparaging the work of others.

This type of displacement activity can take place in any area of work. Much of the time it is not carried out wilfully or even consciously. In stressful and difficult circumstances, it can be seen as an attempt to find a personal comfort zone at another worker's expense.

CASE STUDY

Failure to work together

Joe Simpkins is a care manager. He has a case where the client is 88-years-old, barely being maintained at home and desperately in need of a permanent nursing placement. The client's family are putting Joe under constant pressure to get it sorted out as soon as possible. Joe has done his assessment and completed all the necessary paperwork, funding has been approved.

The problem is there are no nursing beds in social services contracted homes within a 40-mile radius. There is a private nursing home but their fees far exceed the social services benchmark figure. The family take every opportunity to lobby whoever is involved, to 'get the thing moving'. Joe has explained on several occasions that the private bed cannot be used unless the family want to top up the fees, but they are unable to do this.

District nurses visit regularly; they are also feeling the pressure. The district nurses understand the situation perfectly well but when confronted by the increasingly distressed family members they occasionally lapse into saying things like 'If only social services pulled their finger out', or on one occasion 'I'm not sure whether Mr Simpkins quite understands just how risky the situation is.'

Questions

1 Do you think Joe and the district nurses are working together effectively? Give reasons.
2 What effect do you think the nurses' statements have for Joe, the client, the family?
3 What effect do you think the comments have for the nurses?
4 How could collaborative working be improved in this case?

In the case study above, there are likely to be personal factors at work but these can be put in the wider context of scarce resources and different organisational cultures. This is a good opportunity to look at some of the research which has tried to understand why inter-agency collaboration has not always worked particularly successfully.

University of Birmingham, Health Services Management Centre (Dr Tim Freeman and Professor Edward Peck) have produced a report, *Provision of*

Model	Issue(s)
Care Trust	- Possible political difficulties as may be seen as an 'NHS solution' by local authority partners. - Not clear whether Care Trust is now a commissioner or provider model and to what extent it still has Department of Health support.
Community Foundation Trust	- Some Department of Health ambivalence perceived out in the field, presumably due to its potential monopoly provider status and creation of additional (and elaborate) formal governance structures. However, governance model promises community engagement. - Fears over PbR (possible loss of local provision). - Scope of Monitor's regulatory influence.
Social Enterprises	- Concerns over transfer of NHS and LA pensions. - Asset locks of some models may be attractive to staff who value a community ethos, but risk potential investment by private sector partners and reification of current patterns of provision. - Application of EU procurement rules and need for market testing could lead to uncertainty and loss of contracts.
Mental Health Partnership Trusts	- Concern over loss of 'local' emphasis (especially if expansion into area by adjacent existing Partnership trust). - Concern this is an NHS model not engaging local authorities. - Return to monolithic Mental Health Institutions of the past.
Arms Length Management Organisation (ALMO)	- Transferability of model from Social Housing and legal framework (not-for-profit company limited by guarantee).

Summary table: provider models and associated issues

***adult services in partnership between health and social care: Considering the options*, based on a closed seminar held on 23 May 2007 at the King's Fund.**

The four geographical areas that they studied are similar to the extent that they are:

- **unitary authorities, and already have co-terminous boundaries across local authorities and primary care trusts;**
- **actively pursuing service integration across health and social care;**

CASE STUDY

Pursuing integration

Wolverhampton has been pursuing integration in service provision for some time. Their vision is for mental health services to be provided by local integrated community-based NHS and social care teams. They expressed concerned about the development of large mental health trusts which have the potential to lose local focus.

They currently have:

- joint governance arrangements for health and social care, with separate provider and commissioner structures, pooled commissioning budgets and integrated service budgets;
- jointly provided and managed services;
- an overarching Framework Partnership Agreement between the organisations and staff (agreed with Trade Unions) to cover all partnership arrangements.

In the context of ten years of joint commissioning and service integration, **Milton Keynes** is pursuing a social enterprise joint venture between health and social care. They are keen to ensure continued local provision anticipating single-access and joined up services focused on well-being. The Milton Keynes pilot is the largest of the Department of Health social enterprise 'pathfinder' sites, and the choice of a social enterprise model (non-profit with social purpose) is intended to ensure continued staff support.

Questions

1 How does your local authority differ from Wolverhampton?
2 Investigate the models above and consider which one your organisation most closely resembles
2 What factors influence the success of partnership agreements?
3 What social enterprise is taking place locally to you?

- 'mainstreaming' mental health services provision within their organisation of adult primary, community and social care services;
- outcome focused;
- pursuing a shared NHS and local authority vision for service development, based on the individual needs of citizens.

Philosophical and professional barriers to collaboration

Van Eyk and Baum (2002) encapsulated many of these difficulties. They found that:

> 1 Staff normally feel loyalty and commitment to the agency in which they work. However, this can make it more difficult for them to think or work at an inter-agency level, which could potentially involve shifting resources or services between agencies. The addition of institutional and professional politics (both within and between agencies) can contribute to this difficulty. The research showed that there can be a 'them and us' attitude both *within* and between *different* professional groups, which can work against inter-agency collaboration.
>
> 2 In some cases, 'them and us' attitudes can be attributed to a response to new and threatening experiences and approaches. In other cases, they can arise from pre-existing views about other professional groups or approaches.
>
> 3 Tensions between professional groups and between agencies are accentuated at times of budgetary difficulties, when services are overstretched and under-resourced, and when staff feel that they are under threat because of the possible transfer of their responsibilities or services to another professional group or agency.
>
> (Van Eyk and Baum, 2000, pages 262–5)

It would appear that because agencies have not been convinced of the possibility of 'collaborative advantage', they have tended to adopt a defensive posture towards inter-agency collaboration and have not fully committed themselves to joint working. In addition, developing and maintaining relationships with others requires the investment of energy, time and other resources such as training. In order to commit themselves to this, individual workers need to be freed up. If this does not happen then the worker's other commitments will suffer as a result and the whole experience will be stressful and will more than likely undermine collaborative working rather than support it.

REFLECT

1. What are the expectations from within your agency that you, as a worker, will invest energy, time and other resources in developing and maintaining relationships?
2. If the answer is that there are clear expectations, how much have you been freed up to properly commit to this task?
3. If you haven't got enough time, energy or other resources, how could you improve your situation?

Doubtless, different workers will have their own individual responses to the activity. However, some general points can be made.

1. If agencies commit themselves to collaborative working at the top level and back this commitment up with the training, time and other support necessary for their workforce to make it happen, then the chances of this being successful should be relatively good – assuming that the other agencies are similarly committed.
2. If, on the other hand, agencies commit themselves to collaborative working at the top level and don't back this commitment up with the training, time and other support necessary for their workforce to make it happen, then the chances of this being successful must remain doubtful. The reality will not live up to the rhetoric.
3. We have already hinted at a third possibility, which can probably best be summed up by the phrase 'it takes two to tango'. If one agency is fully committed to collaboration, with all the necessary support, but the other agency isn't ready or willing to collaborate – or is, but only on a rhetorical level – then the chances of successful collaborative working are slim.

Earlier, we acknowledged the difficulty faced by individual workers because they have to work within an organisational structure and fit into a certain work culture. Where there is a strong 'top-down' management style, the power of individuals lower down the hierarchy to effect change is limited.

CASE STUDY

Barriers to collaboration

A social services team is contacted by a senior district nurse from one of the local surgeries. The district nurse wants to speak to the team manager. However he is busy and asks the duty social worker to pick it up. The district nurse explains that with two new staff starting soon, they would like, as part of their induction programme, to spend some time with the local social services team. The duty social worker takes down the request and passes it on to the assistant team manager to attend to. Amongst all the new referrals to sort out, the assistant team manager doesn't manage to get back to the district nurse until the following week. The district nurse repeats her request. The assistant team manager says he's sorry but it might have to wait because things are so stretched at the moment, no one's really got the space. The district nurse decides to leave it. Things move on and the two new district nurses never make their visit.

Questions

1 How does this kind of scenario make collaborative working harder to achieve? What messages or lessons will the local district nurses take from this?
2 In the circumstances, what could the social services have done to at least have made some sort of positive gesture? Could, for example, the duty social worker have made their own positive response without passing it on? What reasons might there be for this not happening?

However, whatever the management culture of the organisation we work in, it is what occurs at the level of interpersonal relationships that still matters.

Stereotypes

Different professional groups often hold negative stereotypes about each other. The more entrenched the stereotypes – particularly if they are negative – the harder it will be to develop joint working.

It is worth reflecting on why the urge to stereotype is so powerful. Stereotyping 'fixes' and homogenises people. Stereotypes also tend to distort by oversimplification – which is part of their power. These days, to talk of stereotyping is to imply a narrow-minded, inflexible and prejudiced way of thinking. All of us do, however, stereotype all of the time.

To relate stereotyping to this chapter's theme, we should remind ourselves that through stereotyping people lose their individuality. We can see stereotyping people as an attempt to control or have power over them. Placing people in 'a box' and attributing certain general characteristics to individuals merely because they have a certain look, accent, title, job or role helps us deal with fears, anxiety or uncertainty. It establishes our position in relation to 'the Other'. By saying, for example, 'that's typical of a doctor!' we are communicating to others (but also to ourselves!) how familiar with and unthreatened we are by them. It helps us to think we 'know' them and what they are about. We have put 'the Other' in a box. Stereotyping is a both a functional and dysfunctional activity because whilst it helps us feel less threatened by a complex and potentially overwhelming world, at the same time it also locks us into a rigid and distorted way of looking at things.

REFLECT

1 Do you agree that to stereotype is put 'the Other' in a box? What other reasons might explain our need to stereotype?
2 Write a list of all the other workers who you come across or work with.
3 For each of them write down what the stereotyped view is of their role – this can be positive or negative.
4 Which workers are most stereotyped?
5 In your workplace, how strong do you think the stereotyping of others is and what effect, if any, do you think it has on collaborative working?

To conclude this exploration of how different groups of workers stereotype one another, we must recognise that if we are stereotyping others, then the chances are that they are stereotyping us. We are not immune. In which case we need to be able to break out of our box and assert our individuality. If we can do this, we greatly improve our chances of developing productive professional relationships.

REFLECT

Think about your job. In what ways do you think it might be stereotyped in the eyes of others? Do you think the stereotype varies according to which type of other worker is doing the stereotyping?

It is not enough just to feel aggrieved by being stereotyped by others – irritating as it might be. All this will probably lead to is more stereotyping! We need to be able to take steps to ensure that others find it difficult to lapse into a stereotyped picture of who we are and what we do.

The first point to realise is that if we are suffering from a stereotyped image, it's nothing personal. Blaming the other is not helpful either because, as we've seen, everyone stereotypes at one time or another. It's therefore usually not malicious. The most effective way of combating others' stereotyping of us is to ensure that they get to know us as an individual. This means that we have to think of strategies to have more contact, and preferably contact that is not always linked to specific cases. We discuss various ways of improving relationships in the next section.

Working in partnership at organisational level

Cultural differences

In addition to stereotypes, there are real and very important cultural differences between professional groups in terms of how they understand and respond to need. The same could be said for different organisational cultures. It is important to be aware of such cultural forces because the pressures to conform for individuals who are subject to them are very strong. In reality, it is unlikely that an individual worker could operate freely from the pressures and constraints of the work culture they are in. Therefore, a worker wishing to work collaboratively with others, but who works within a culture where this isn't valued or supported, would experience serious problems. These cultural differences include the use of jargon particular to each profession. In terms of joint working between health and social care professionals, tensions can also arise from differences in the dominant model of care each worker works to. The medical model and the social care model, for example, differ over how best to respond to the needs of service users and how clients should be treated.

We discuss the implications of workers within a medical or social model in Chapter 7 on assessment. Having earlier discussed the dangers of stereotyping it is worth reminding ourselves that not all health workers approach their work according to a strict medical model. Neither, for that matter, do all social care workers understand and fully embrace the social model. It would be too easy to caricature the work of others in this way. Medical and social models are not the only agency cultures that we need to consider. For example, the statutory social care sector, with its local government traditions, together with its tradition of means testing and charging for services, is a strongly bureaucratic culture. Care providers in the private sector have more of a commercial/business orientated culture. Voluntary agencies have their own culture.

ACTIVITY

1 Have a go at describing your own professional/organisational culture. Use any of the terms from the list given plus any others that you think are appropriate.

client-focused, caring, bureaucratic, organic, mechanistic, medical model, social model, innovative, entrepreneurial, creative, siege mentality, defensive, cost-conscious, oriented to customer satisfaction, hierarchical, rigid, flexible, open, closed, dynamic, undynamic, responsive, warm, impersonal, businesslike, efficient, wasteful, client knows best, worker knows best, empowering.

2 Because our theme is collaborative working, take a look at your list and identify those aspects of your professional/organisational culture that help collaborative working and those that don't.

often more flexible and less profit-minded than the others we have mentioned. Over and above these broad sectoral organisational cultural differences, all workplaces and agencies are bound to develop their own 'micro cultures' depending on factors such as the individual management style, the make-up of the workforce, location, availability of resources, type of agency and so on.

The value of this exercise is that it can help to know the obstacles we face in forming effective collaborative relationships. We shouldn't, for example, accept or attribute personal blame for what are larger, cultural factors. Trying to understand the points of friction between your professional or organisational culture and that of those you need to collaborate with can make it easier to develop links. This is because you can not only understand better the other worker's ways of working but you will be aware of the controls and constraints they face. If the overall cultural differences are too strong then, as we have argued, the individual faces a very difficult task.

Jargon

A key aspect of organisational and professional cultural differences is that different work groups develop and speak their own jargon. Jargon is a kind of specialist language that groups use. Using jargon has the effect of excluding those outside the group because they don't know what the specialist terms mean. As such it is disempowering and a definite barrier to communication.

When people enter residential care it is good practice for their GP to send in a medical report outlining the patient's physical and mental state of health, any medication and any specialist involvements. Quite often these reports are peppered with medical jargon such as 'suffered several TIAs over last two years', 'ca lung in remission', 'recovering from ARF', 'sups to be given PR'. It is not uncommon for the care home staff to have to phone the surgery for a translation; either that or they discuss it amongst themselves and proceed on the basis of informed guesswork. This is not only to save the time in having to call the surgery but often to avoid the embarrassment of revealing ignorance to a fellow worker. It is also not uncommon for residential care staff to ring the social services care manager to find out what a certain piece of medical jargon meant. Usually they cannot help but it is more time wasted.

It is not just health workers who use jargon unthinkingly. An occupational therapist, following up a referral to her local social services, was told crossly 'If it doesn't come in on a Soc 358 it won't get looked at.' There are plenty of these examples and the effects vary. However, to summarise, the use of jargon can:

- lead to people's needs not being met properly
- exclude other workers, the client and their carers
- disempower other workers, the client and their carers
- create unnecessary barriers to communication
- waste time
- cause unnecessary irritation
- lead to misunderstandings with injurious consequences
- lead to a hardening of professional boundaries.

REFLECT

1. Think about your own agency or place of work. Are you a jargon-free zone or do you use jargon at times? What is it?
2. What about workers from other agencies? Do they use jargon? If so, what is it and what effect does it have?
3. If you do face jargon from others, think of constructive ways in which you could ensure that colleagues in other agencies could be educated out of it.

Roles and responsibilities

If professionals disagree over their respective roles, responsibilities and competences, then this is likely to be an obstacle to effective joint working at the local level.

We have already talked about the importance of workers being clear about their own job role. However, the principle of close collaborative working raises some important issues around roles and responsibilities. Individual workers might well be clear about their own role but that can still leave 'territorial' disputes about 'who does what' when there is potential for more than one worker to perform a particular task. The experience of different types of multi-disciplinary team is often that, while workers retain certain key specialisms, there is also some blurring of professional boundaries. Many of the tasks carried out for clients are 'generic' – they do not require a particular professional specialism and can be performed by any member of the team. How these so-called 'generic' tasks are allocated can be the source of friction. The blurring of professional boundaries around generic tasks suits some workers better than others. Workers are reluctant to give up high status work for something which might be considered lower status.

What are high and low status tasks? Clearly, there is some room for discussion here. However, under high status work we might include:

- tasks that require specific professional expertise
- tasks that allow the worker to use their professional discretion and judgement
- tasks that can be carried out autonomously or with a high level of autonomy
- tasks that can further our career (good CV material!).

Under lower status tasks we might include:

- routine form filling and paperwork
- tasks that have a low skill content and permit no professional discretion
- tasks that allow little or no autonomy
- tasks that add nothing to one's CV.

Multi-disciplinary working can sometimes end up as an exercise in the 'cherry picking' of the high status tasks and its corollary – the avoidance of as many low status tasks as possible. Many collaborative working situations in care involve a lot of valuable but nevertheless, low status tasks – these are the 'bread and butter' of care work. This can provoke friction and disagreement amongst workers when it comes to negotiating who takes on this work. Often, the worker with the weakest professional identity loses out. When we use the term 'professional identity' here, we mean the sense workers have of what their professional skills and knowledge are. This would also apply to how clear workers are about their professional roles and responsibilities. A strong professional identity is where the worker is clear and confident about their particular skills and knowledge base. The opposite would be the case when the professional identity is weak. This discussion raises questions:

- How is it decided and agreed which tasks are generic?
- How are boundaries drawn around each worker's role and responsibilities?
- Who decides who is competent to perform certain tasks?
- How should the low status tasks be shared out?

Ironically, successful collaborative working can often stall over the 'bread and butter' matters – or the question of who does the donkey work. This is because the obvious specialisms are taken care of, but the mass of generic tasks are not so clearly allocated.

CASE STUDY

Working out roles and responsibilities

The newly formed management of a Mental Health Trust have embraced the principle of collaborative working and has urged the team members to work as generically as they can. The team is made up of community psychiatric nurses (CPNs), occupational therapists, a psychologist and social workers. 'Territorial disputes' arise in the team when it is explained to the CPNs that when they feel one of their clients would benefit from home care or day care, they must commission it themselves and complete all the necessary paperwork. The CPNs make it clear that they resent having to undertake a task they expect the social workers to do. They claim they are 'not bureaucrats' and it is a waste of their time and expertise. When things come to a head, they argue that because the social workers are not sufficiently well trained to do the CPNs' job (for example check medication and other clinical issues) they don't see why they should do what was traditionally a social work task.

Questions

1 How can this dispute be seen in terms of high status and low status tasks, strong and weak professional identities?
2 How do you think the social workers should respond to this dispute?

In attempting to answer the second question in this scenario, and at the same time promote the cause of collaborative working, the social workers could make several responses. An understandable but ultimately unhelpful response would be for the social workers to take umbrage and embark on a frosty relationship with their fellow team members. What they really need to do above all is to speak to each and clarify in their own minds what their role and responsibilities are and to be clear about what their specialisms are. If the social workers can work on strengthening their professional identity, for example by establishing their assessment and interpersonal skills, their values and identifying what their particular areas of expertise are – for example, dealing with adult abuse or complex legal matters – then the subsequent discussions can be more of a negotiation between equals. The trading can take place with more equanimity if each party can respect the professionalism and expertise of the other. It would help with the process of sorting out who does their share of the mundane tasks. To be uncertain and unconfident about one's job role and responsibilities is no position to bargain from.

Misunderstandings

Workers often have only limited knowledge about other professional groups or other organisations with which they wish to liaise and work. They simply misunderstand the priorities, organisational structures, cultures and working practices of fellow professionals. There is a lack of 'network awareness'.

This point returns to the discussion at the very beginning of the chapter, where we asked 'Do we know who else is working with our clients?'

From this we have to acknowledge that:

- in the first place, there are times when we simply don't know who else is involved
- on other occasions, we have a vague idea of who is involved but are not clear about the nature of their roles and responsibilities.

REFLECT

What reasons might there be for not knowing who else is involved in work with our clients?

One obvious reason probably springs to mind: the client and/or their carers do not communicate this information to us. This might be because they are unwilling, unable or they simply don't think it's relevant. For many people, it suits them to compartmentalise their lives. It might be easier for them to deal with different workers in isolation. To some extent, if this is a preference we shouldn't simply ignore it. Quite often people complain about workers coming along 'poking their noses into our business'. If this is their attitude, they might well withhold information about other involvements. This desire to protect one's privacy is not an uncommon feeling amongst service users. We should accept that it poses dilemmas for workers. We need to think seriously about whether and in what circumstances we need to seek someone's permission in order to share information about them. What is collaborative working for us may feel like 'plotting behind their back' to clients.

CASE STUDY

Finding out the facts

The care manager goes to assess Albert Jackson. He is an older man whose wife has recently died. The neighbours are concerned and think he needs opportunities to get out and meet more people. When the care manager gets there Albert admits to being lonely and missing his wife but turns down the offer of day care. The care manager tries to get as full a picture of health and social care needs as possible but Albert says that mainly he is OK and he'll be in touch if he needs anything. The care manager is on the point of 'closing the case' the following week when the district nurse rings up. She didn't know that the care manager had visited but wanted an assessment to be carried out for personal care as much as anything. This, she explained, was because she visits regularly to assist with Mr Jackson's colostomy bag. His personal hygiene has become noticeably worse since Mrs Jackson died; in addition, laundry is just piling up in the bedroom.

Questions

1 Why do you think Mr Jackson failed to mention such an obvious involvement to the care manager?
2 What lessons does this teach us about relying on the person concerned, their carer or even the referrer to inform us about other involvements?

This links us to the second point about being aware of involvements but not being very clear about what they are. If we rely on clients and/or carers to inform us precisely about the involvement of others, the information we get may be very limited. People can be less than forthcoming for the kinds of reasons set out above. Apart from problems with memory and confusion, or communication problems, they may choose to be deliberately vague. This, almost certainly, is not out of a mischievous desire to play games: it is more likely an attempt to retain some sort of control or power over the situation when they are feeling at their most vulnerable.

People in crisis or distress have to 'lay themselves bare' to strangers. It can be a humiliating and exposing experience. It is often something they want to remain silent about, particularly when they are faced with yet another stranger.

We have established that discovering the make-up of someone's care network is not always straightforward. It might require not only time and effort checking various sources, but also having to deal with dilemmas about respecting privacy. However, even when we are aware of various involvements, the second point we need to address is that workers can often possess limited knowledge about other professional groups or other organisations. For example, even if we are aware that, say, an occupational therapist, a member of the 'Rapid Response' team, or a day services support worker is involved with one of our clients, this does not mean that we are always entirely clear about what they do and what they are responsible for. This clearly poses problems for effective collaborative working. One obvious problem is how to ensure that the expectations we have of other workers is realistic and vice versa. There are many reasons why we aren't clear about the roles and responsibilities of others and this suggests that we should ask how we discover such knowledge.

It would be entirely reasonable to have a range of scores. Hopefully, there are no zeros! It is interesting to reflect on how we know what we know about each other's roles and responsibilities. Those whom we actually meet regularly and work with the most frequently probably score the highest. However, we might also acquire our knowledge of, say, a GP's role from our own personal contact as patients – that wouldn't be unreasonable.

ACTIVITY

1. Write down a list of the workers who become involved with your clients.
2. Now, write down a score against each worker on a scale from 0 = 'I know nothing about this role', to 10 = 'I know just about everything there is to know about this role.'
3. Lastly, for each worker, write down how you actually gained that knowledge.

What about those workers to whom you gave a low score? You might, with some justification, expect a textbook such as this to be able to fill in the missing details. That, after all, is what we expect from books. If you think about it, is this the best way to familiarise yourself with the specific roles and responsibilities of those working in your locality? For example, across the country there are groups of workers with names like 'Community Support Team', 'Crisis Intervention Team', 'Community Resource Team', or even 'Assertive Outreach Team'. They all are working in the field of social care for vulnerable adults. However, depending on the locality they could be doing completely different things for different client groups. There are workers with job titles such as GP Liaison Worker and Assistive Technology Officer. What one does in one area may not apply in another. In some areas the NHS might have a Falls Coordinator in others they might be called the Falls Prevention Officer, each with slightly different responsibilities. No single textbook, however well researched, is going to adequately cover this plethora of different roles. This means that workers need to gain the necessary information in ways that are appropriate to them and where they work. Workers need to take responsibility for finding out this information on the ground for themselves; there is no better alternative.

With your lists from the previous exercise, think about how you personally could get a clearer picture of what those workers do. We discuss some methods for doing this in the next section.

Lastly, a further complicating factor is that whilst certain individual workers have a particular talent for networking, others have the capacity to undermine joint working through the way they think and behave. This is to say that some people are simply not 'clubbable'; their overall approach to other workers is to annoy them with a bureaucratic, officious, often pedantic manner. They may lecture others on what their responsibilities should be, talk at length about why doing their job is 'not as easy as you think', and generally maintain a 'yes but' attitude to approaches to work collaboratively. When you encounter such people, if all else fails it can be simpler to work around them rather than waste further time and energy.

Organisational boundaries

In recent years, particularly to advance the cause of 'joined up' government, attempts have been made to make the various health authority and local authority boundaries coterminous – that is to say, the boundaries of responsibility for health authorities and local authorities have been redrawn to match the same geographical area, whether this is a town, region or county. There are unfortunately still quite a few exceptions. This means that a health authority can have responsibility over, say, the whole of one county, the southern part of another, and the western part of another. A single health authority is therefore dealing with three different local authorities, or maybe more if there is a unitary authority embedded in a larger county authority. A local authority might have two or more health authorities with responsibilities in different parts of its area of responsibility. This can cause problems at the level of strategic planning. These need not be insuperable but it does mean more people to meet with, negotiate with and to agree plans with – and more chance of confusion.

At a more local level, it is usually the case that several GP surgeries operate within the boundaries of a single local authority. However, the way that a local authority divides up its area, for example in East, West, North and Central divisions, can often mean that one surgery has half its patients in the East division whilst the other half are in the West division. Here, the problems involve having two different managers and two sets of workers – each with their own subtly different ways of working; there are twice as many links to make and maintain.

At ground level, care practitioners are not always sure whether a person living in a particular street is the responsibility of Dr Smith's or Dr Jones' surgery. Health workers refer to one locality social services team when they should be referring to another because they are not entirely sure where the boundaries are drawn. The possibilities for confusion and the wasting of time are made more complex again once the different catchment areas of housing and education authorities are factored in.

REFLECT

Think about the various agencies involved in your area. As far as you know, are they working 'coterminously' or do they straddle one or more areas? Are there any problems?

CASE STUDY

The importance of localism

Portsmouth has separated its provider and commissioning functions. It maintains a wide range of directly provided services and has a history of good relationships between health and social care including integrated mental health provision. The PCT attained the second highest score in the national Fitness for Purpose process, and has a very strong vision for the provision of services for local people within the local authority. Localism and geographical community are considered to be of paramount importance, and agencies are keen to promote integrated local service provision – the fear is that an emphasis on **contestability/competition** may distract attention from risk and patient safety, and threaten local provision.

Questions

1 What do you understand by Portsmouth's commitment to 'localism and geographical community'?
2 Do you think that competition between service providers improves quality and value for money for those who purchase and use services?

As we have seen, the government is in favour of a seamless service and PCTs are meant to be an important step towards this. In addition, other initiatives such as NHS Direct and Care Direct are meant to create one-stop 'portals', whereby the person needing help only has one door to go through.

It is too early to say whether these initiatives have solved the problems caused by lack of coterminosity.

Data protection and confidentiality issues

All workers should be legitimately concerned about data protection and confidentiality issues. However, an eagerness to keep information safe can lead to an unwarranted withholding of information. Timely and effective interventions can sometimes be badly stalled by an overprotective mentality towards information sharing. The way in which different professional workers share information between themselves is far from settled. Different agencies are still reluctant to share information electronically for example, because there are concerns about security. Proper 'firewalls', passwords, and other access arrangements need to be put in place before one agency is prepared to pass its case information across a computer network to another. However, IT security concerns are not the only problem.

KNOWLEDGE CHECK

1. Track down your agency's policy on data protection and guidance on confidentiality. Thoroughly familiarise yourself with the contents.
2. List factors that can prevent effective working in partnership.
3. Why might stereotyping pose problems in professional relationships?
4. Give two examples of how different professional or organisational cultures may get in the way of successful joint working.
5. Explain why, in multi-disciplinary teams, disagreement over roles and responsibilities can lead to friction.
6. Explain why workers don't always know why others are involved.
7. How can having only a vague idea of other workers' roles and responsibilities impede working together effectively?
8. What does 'coterminous' mean and what effect can a lack of 'coterminosity' have?
9. What does data protection legislation tell us about the way information on clients is recorded, stored and managed?

Effective collaboration

In the previous section we discussed a range of problems that can create obstacles to successful collaborative working. Some of the solutions are beyond the powers of the individual worker and are more appropriately the responsibility of politicians, policy makers and senior managers.

The practical conditions for integration appear to require the following.

- Formal validation from above – often lack of central or management support for integration make the task of integration challenging.
- High level of local control – when resources, like Supporting People, are under local authority control they can be integrated, but where control lies elsewhere then integration seems to fail.
- Incentive to integrate – where resources are treated as belonging to a different part of the system then there is no incentive to make integration happen.
- Aligned local leadership – where management systems for different funding streams are aligned under one leader then integration is easier.
- Clarity of process – where the local leadership has one clear template for the final organisation of Self-Directed Support then integration is easier and more coherent.
- Strong sense of mission – where local leaders have a strong sense of purpose and are eager to bring about change integration is easier.
- No strong restrictions on process – where there is little flexibility in how processes can be re-engineered then integration becomes impossible.

(Waters and Duffy, 2007)

Improving community safety for older people

In March 2005, Barnsley Metropolitan Council Local Area Agreement committed local health, social care and housing agencies to share objectives within their Local Area Agreement, to improve community safety for older people. Their intention is 'to decrease the number of older people requiring hospital admissions as a result of a fall and achieve a reduction in the number of admissions to residential or nursing care as a result of a fall.'

However, there are clear messages and lessons to be learned for workers at every level. Collaborative working is most likely to be effective if certain key principles are followed:

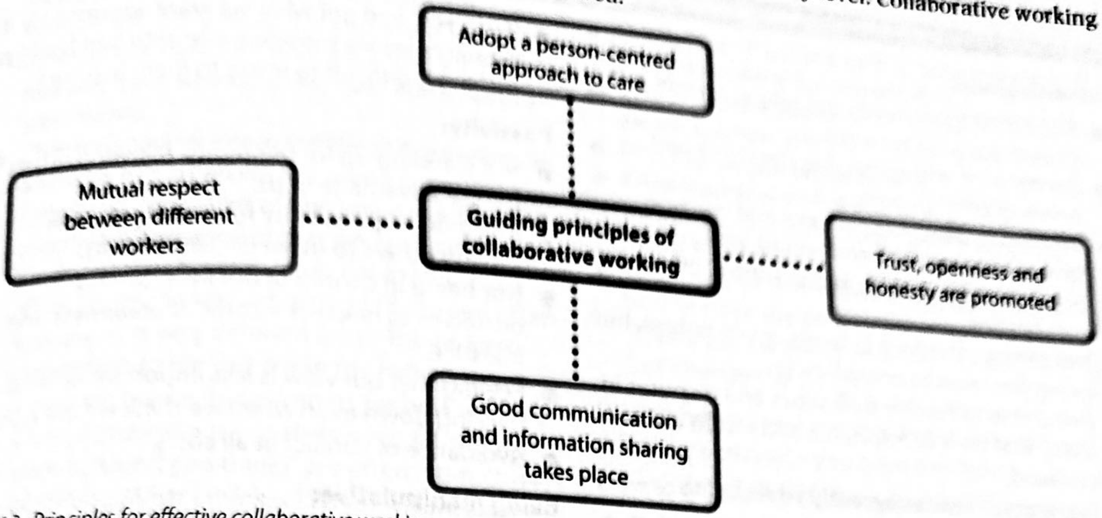

Adopt a person-centred approach to care
Mutual respect between different workers
Guiding principles of collaborative working
Trust, openness and honesty are promoted
Good communication and information sharing takes place

Figure 6.3 Principles for effective collaborative working

Skills for collaborative working

If we can work to the spirit of these basic guiding principles then it should be easier to overcome some of the obstacles we have identified. Our effort to work collaboratively will benefit both from acquiring and practising certain skills and adopting certain methods and strategies.

ACTIVITY

Given all the possible issues we have uncovered, make a list of all the skills and qualities you think are needed to ensure that we can establish good working relationships with other workers.

Your list is probably very similar to a list that you would make if asked what skills and ways of behaving you need to work in care. This would typically contain the following:

- being a good communicator
- having good interpersonal skills
- being non-judgemental
- being genuine.

Therefore, this does not necessarily involve the acquisition of specific new skills. However, in the light of some of the potential difficulties we have discussed in earlier sections, the following skills and ways of behaving are going to be particularly important.

Assertiveness

Assertiveness is a vital ingredient to working in social care and particularly when it comes to being effective in partnership working. The non-assertive worker denies their own rights and will forever find themselves in a subordinate (inferior) role with others, accommodating their interests, needs and wishes to the detriment of their own.

Assertiveness is a state of mind which requires you to know who you are and what you want. It is a way of behaving that enables you to communicate this knowledge clearly and effectively to others. It runs wider than just the ability to say 'no'. Assertiveness is often confused with selfishness or aggression, with putting our own needs before those of other people.

REFLECT

Which approach(es) do you have: aggressive, manipulative, passive or assertive?

Basing your decisions on what is described above, reflect on which approach you adopt in your day-to-day dealings with other workers. Which approach most characterises the way you work? Does it vary according to who the other worker is? Explain.

What do you need to do to become more assertive?

Assertiveness:

- Recognising our needs and asking openly and directly for what we want.
- Recognising and respecting the rights and needs of other people.
- Relating to people in personal and working situations in an open and honest way.
- Feeling responsible for and in control of our own actions.
- Not seeing situations in terms of win or lose, but being prepared to compromise.
- Being able to resolve difficulties and disputes in a way that feels comfortable and just to those involved.
- Expressing views coherently while being prepared to listen.

Aggressiveness:

- Expressing feelings and opinions in a way that punishes, threatens or puts the other person down.
- Disregarding the rights and needs of others.
- Aiming to get our own way no matter what.
- Views made forcefully to the point of rudeness.
- If we 'win' and get what we want aggressively it probably leaves someone else with bad feelings, making it difficult to relate to them in future.

Passivity:

- Not standing up for our rights. Allowing others to take advantage of us.
- Avoiding responsibility for making choices – leaving others to make decisions for us.
- Not being in control of our lives. Seeing ourselves as helpless victims of unfairness and injustice.
- Feeling that our view is less important or valid – backing down even when we think we are right.
- Avoidance of conflict at all costs.

Being manipulative:

- Unable to ask directly for what we want.
- Trying to get what we want indirectly, by playing games or trying to make people feel guilty.
- Expressing views in a covert manner. Often using snide remarks, gestures and facial expressions.

and pursuing them regardless of the effect on others. This is *not* assertiveness. Let us look at what assertiveness really is and compare it to other ways of relating to people's aggressiveness, passivity and being manipulative.

In becoming more assertive we develop awareness both of what we say and how we express ourselves.

Becoming more assertive

If you found that you were able to be properly assertive with other workers, whichever agency they are from, that is fine. If, on the other hand, in some situations you find this difficult, you need to do some work.

Some basic guidelines to becoming more assertive

Verbal aspects in becoming more assertive:

- *Aim to personalise pronouns* Use 'I' statements rather than 'You', 'It', 'We', 'One'. Using the personal pronoun 'I' acknowledges that the statement is true of our experience and that it may be different for other people.
- *Changing verbs* Change 'can't' to 'won't' where 'can't' is not an appropriate restriction.
  This change of verb encourages us to take responsibility and to be aware of what we can and cannot realistically do, and that we can make a positive choice when we decide whether or not to do something.
  Change 'need' to 'want' and differentiate between the two. This change of verb encourages us to be realistic and responsible about what we need and want.
  Change 'have to' to 'choose to'. These changes in verbs acknowledge that we make a choice about what we do and are therefore responsible for the choice. This realisation that we have choices is an important part of becoming more assertive.
  Change 'know' to 'imagine' when a fact is a

fantasy. Often we state we know something about someone when in fact we base this 'knowledge' on fantasy. It is important to differentiate between what we know, imagine, feel and think when making clear and assertive statements.

- *Changing passive into active* We put ourselves in a passive role when we talk about something happening to us. Part of becoming more assertive is recognising that we are responsible for things that happen to us. For example, 'I allow people to take advantage of me and often feel angry' is very different from 'Things keep happening to me that make me feel angry', in which we blame things/others for how we feel.
- *Changing questions into statements* Questions such as 'Don't you think?' are often indirect ways of stating 'What I think ... ' When we are clear and direct in our communication we are more assertive with ourselves and others.

There are non-verbal aspects to becoming assertive:

- *Eye contact* How a person looks at someone conveys how they feel about themselves and what they are saying.
  It is a powerful form of self-assertion to look someone directly in the eye. A person will often give their power away by looking away. When a person looks directly at who they are talking to they communicate that they are alert and present in themselves.
- *Posture* How a person stands or sits also communicates how they feel about themselves and what they are saying.
  When a person is standing talking to someone or addressing a group of people it is important that they stand with both feet firmly on the ground. This means that they are both centred and balanced in themselves.

You can assert yourself by saying no to whatever you dislike or disagree with. But why do we find saying 'no' difficult? There are many possible reasons but some common ones are:

- We don't want others to think us unkind.
- We want to be popular.
- We think we should be all things to all people.
- We think our refusal might devastate the other person.
- We may have been brought up to think saying no is impolite.

Hints for saying 'no':

- Get the word 'no' out early in your response, if possible make it the first word.
- Give reasons if you need to, but don't make excuses; others will see through them.
- Don't apologise unnecessarily.
- Keep your non-verbal message assertive; maintain good eye contact and don't smile inappropriately.
- When you've finished making your point, find a way to close the conversation such as 'OK?', 'Thank you for being so understanding' etc., or just change the subject.

Remember, you are turning down a request not rejecting a person – you have the right to say no!

How to criticise or challenge someone assertively:

- Before you start, work out a sound inner dialogue to make sure the criticism is specific and not a personal attack.
- As you criticise, introduce a topic and (if appropriate) say why you are raising it.
- Specify what the problem is.
- Get a response to your criticism.
- Ask for suggestions to rectify the problem.
- Summarise suggestions agreed.

How to respond assertively to criticism or a challenge from someone:

- Listen to the criticism carefully, rather than rejecting it or arguing with the person.
- Ask yourself whether the challenge is valid/invalid and/or whether it is in the form of a put-down.

If the criticism or challenge is valid:

- Acknowledge that it is true.
- If it is generalised then ask for more specific information.
- Ask other people for information, whether or not they experience you in a similar way.
- Decide whether or not you are going to change your behaviour as a consequence of the criticism.
- Thank the other person for their challenge/criticism.

If the criticism or challenge is invalid:

- Say so and assert yourself positively, for example:
  'You have made a mistake in your assessment.'
  'No, that isn't true. I am usually very careful.'

- When criticisms are made that are invalid, affirm yourself.

If the criticism is valid and in the form of a put-down:

- Acknowledge that it is true! Challenge the put-down and assert yourself positively.

It is important with put-downs to respond assertively and to confront the put-down, for example:

'Typical of you – you never return my emails.'

'Yes, I have not yet responded to the last two. However, I usually respond to all my emails as soon as I can and I don't like your put-downs!'

If the criticism is invalid and in the form of a put-down:

- Say so. Challenge the put-down and assert yourself positively, for example:

  'No, that isn't true, I have answered all my emails and I don't like your put-down!'

Our discussion on assertiveness has probably made you realise just how important our use of self is in conducting effective relationships with other workers. It should also have reinforced how important it is to possess a clear professional identity. Low professional self-esteem and successful working in partnership are incompatible.

Clear sense of own role

We have seen how difficult it is to be assertive and therefore work effectively in collaboration with others if we have self-doubt about our own worth, our own competence and our job role. It is therefore of paramount importance that, as workers, we clarify what our job role is and what responsibilities it carries with it. This question will have been raised many times and we want to be sure that the lessons have been learned.

REFLECT

Imagine you have been asked to give a talk to a group of service users, your colleagues and other workers. You have fifteen minutes to make it absolutely clear to all of them what you do, what you are responsible for and what you are *not* responsible for; in other words you need to make clear the function of the organisation you work for and your role within it.

How would you structure your talk? Write down your headings together with what you would say. Make a point of identifying areas where you specialise.

If you found that exercise difficult it might suggest that you would benefit from doing some research. Look out your agency's mission statement and any other relevant documents that could help you summarise what business you are in exactly. What does the agency's literature say it is about? Look out your contract and job description. What are your core tasks and key responsibilities? What leaflets or other publicity does your agency have for the public? What do they say about the agency purpose and your role within it? If you are still unclear because, for example, you do not recognise what you do on a day-to-day basis from the official job description, then you should raise this at a staff meeting or some other appropriate forum. There is no shortage of people who are happy to tell us what social care or social work is or should be. Unless we want our roles limited and defined by others we need to have a clear idea of what the purpose of what we do is.

Then we can assert ourselves effectively.

Negotiating skills

To negotiate is to try to reach a mutually acceptable agreement with another party (or parties), usually through discussion. Negotiating is at the heart of social care work. We need to reach agreements with others on a range of matters – some relatively trivial, others more serious. These could be times of meetings, dates when care starts, where to have a meeting, when to have the next review, who is going to take key responsibility or even who is going to give someone the bad news! What we're trying to do is achieve a 'fit' which all those involved are reasonably comfortable with. Because most of these decisions are reached with little or no dissent, we can often take what we're doing for granted.

But clearly even the most straightforward of decisions do not happen automatically. Somebody needs to take the lead, identify what needs to be done, offer suggestions and then make an appropriate response, even if the minimum amount of negotiation is required.

From time to time, we will find that it is hard to obtain a 'fit' or a happy medium and that is when the ability to negotiate becomes very important.

What happens if someone has poor negotiating skills? We've probably all been on the wrong end of situations or 'agreements' that have been badly negotiated. This can leave us with feelings of anger, injustice, being cheated, put upon, outmanoeuvred, or even bullied. This is because the so-called 'agreement' has been settled on the other party's terms. Goodwill soon disappears in such circumstances. It is also equally true that if we impose our decisions on others without the possibility of negotiation, then they too will feel a similar sense of grievance. Collaborative working can only work properly if agreements are negotiated on terms that everybody is happy with.

CASE STUDY

Negotiating a care plan

A care plan has been drawn up for Joyce McCullough, a 41-year-old with schizophrenia. When Joyce, who lives on her own, goes through occasional periods of instability, members of the Community Mental Health team make a point of visiting twice a day to ensure that any risk is managed. The key worker is Damien, a CPN, and he has asked Janet, one of his social work colleagues, to share the task. In the spirit of working collaboratively, Janet agrees. Damien then draws up a rota for visiting which requires Janet to visit at 6.00 pm each day whilst Damien visits Joyce at 9.00 am on his way to work.

Janet would have preferred the earlier visit because the 6.00 pm visit conflicts with a range of other tasks she wants to do – including going home! Initially, no comment is made as Damien says it will only be for a few days. After a week, Joyce is still unstable, and it is clear that Damien has no intention of offering to share the 6.00 pm call. When Janet half raises the issue of changing times, Damien says that the earlier call is more important for him to do because he checks medication – something Janet wouldn't be able to do. Janet feels trapped.

Questions

1 What options are open to Janet?
2 Can a more suitable agreement be negotiated? If so, how?

In your responses you should have been able to link this situation to points we have made previously about power imbalances, professional identity, assertiveness and the need to have a clear job role.

Outcomes which would not promote effective joint working would be for Janet, the social worker, simply to:

- withdraw
- go straight to the team manager, or
- continue but vow never to help that particular CPN again.

Another approach could be for Janet to refer Joyce to the psychiatrist for a case review, and use this as an opportunity to disengage from the situation. However, this would not really be negotiating with Damien, it would be working round him. This could be considered manipulative even if it is in Joyce's best interest. Going straight to the manager would be a later option if negotiation proved unsuccessful. Working collaboratively is about trying to forge reasonable working relationships with colleagues, not trying to outsmart them.

Situations like the one outlined opposite should be resolved by negotiation wherever possible. In order to negotiate successfully in any situation we need to know what we want – it is no good simply grumbling, we must have our own clear proposals. We need to think about what our ideal solution would be; i.e. what would be the best possible result to come out of the negotiation? We then need to be realistic and prepared to concede some ground. This involves having a 'fall-back' option; i.e. what is the least satisfactory solution we would give our agreement to? We need to be clear that we will not go over this line. If someone tries to force us beyond our fall-back position then we need to be clear what we will do. This might involve taking things higher or simply refusing to co-operate further; it depends on the situation. In any event, it is no good having a fall-back position if it is ignored.

Having clearly set the parameters of what is acceptable in our head, we need to be able to argue successfully for what we want. We need to be able to show that our proposals are fair, reasonable and rational. We need to have arguments that reflect coherent care values. They cannot be arguments that can be attacked for being selfish or overlooking clients' needs.

The way we negotiate is as important as the quality of the arguments we use to negotiate with. This inevitably brings us back to assertiveness. If we try to negotiate in a way that is aggressive, angry, manipulative or passive we will greatly reduce the chances of success. If we aim to negotiate in a way that shows us to be open, flexible and reasonable then this will be more conducive to effective collaborative working.

Successful negotiation checklist

1. Am I clear about what I am trying to achieve?
2. Am I clear what my fall-back position is?
3. What will I do if I am pushed beyond my fall-back position?
4. How will I conduct my negotiation – what arguments will I use?
5. Have I got a case which can clearly be seen to promote client care?
6. How will I negotiate in a way that is assertive and not aggressive, manipulate or passive?
7. Am I being open, flexible and reasonable?

KNOWLEDGE CHECK

1. What does it mean to 'be assertive'?
2. How can assertiveness contribute to collaborative working?
3. Make a list of four skills or ways of behaving that will facilitate collaborative working.
4. Have you got a clear sense of your job role? Briefly explain what it is. What are your specialisms?
5. Give examples of negative effects if we possess poor negotiating skills.
6. Identify six pointers from the successful negotiation checklist.

Networking skills

Here we see networking as an umbrella term which includes a range of activities, all of which have 'contact' as an important feature. They include the activities shown in the diagram opposite.

Networking is not a precise science, in many ways it is more of an art. A common way of describing networking is to compare it to a bee busily buzzing around picking up pollen from one flower and depositing it on another. In their research, Means and Smith (1998) found that good networkers:

> ... tend to feel comfortable working above their hierarchical position, and they are willing to operate in a way not bounded by narrow organisational self-interest.
>
> (Means and Smith, 1998, page 143)

How to network

Good networking might be as much a product of personality as a set of skills we can learn. It requires a certain mindset. At a basic level, good networkers are 'chancers' and opportunists, they exploit situations for all their 'contact potential'. They are both active and proactive in their approach.

Therefore, to be able to network effectively, we need to see the value in making contacts.

REFLECT

Reflect on a job that you have done for a long period and in which you have built up a series of personal contacts. How often did you solve problems by drawing on personal contacts that you made or by using a specific agency and organisation that you learned about by someone telling you about them? Contrast this to a job where you have just started in a new locality and where you have little or no knowledge of what networks there are.

Networking is about building up contacts and sharing ideas and information. The more knowledge we have of what is available and who is out there to help, the more our clients have to gain.

In order to exploit situations, we need to have a raised awareness to the possibility of making contacts and be able to seize possible opportunities. We also need to actively create openings and not just wait for them to come to us.

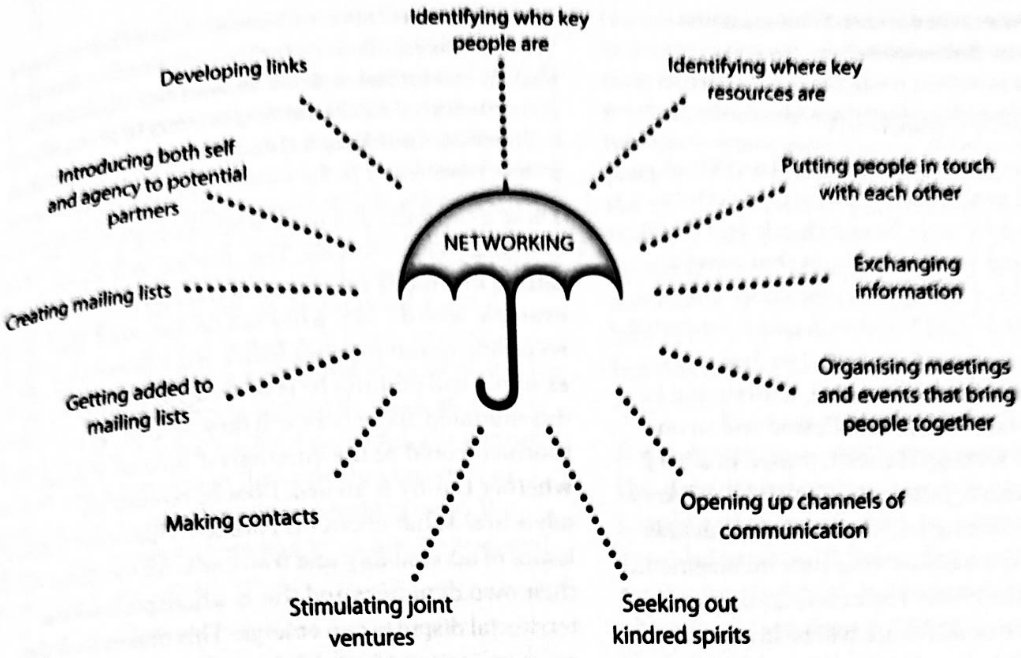

NETWORKING
Identifying who key people are
Identifying where key resources are
Putting people in touch with each other
Exchanging information
Organising meetings and events that bring people together
Opening up channels of communication
Seeking out kindred spirits
Stimulating joint ventures
Making contacts
Getting added to mailing lists
Creating mailing lists
Introducing both self and agency to potential partners
Developing links

Figure 6.4 Networking skills

CASE STUDY

Networking

David is a new care manager for a locality team. He keeps hearing from his colleagues how the rapid response team are always moaning about how slow the locality team is in picking up the work which they want to hand over. There is quite a backlog of unallocated work. David is a bit unclear about what the rapid response team does, but knows that the two teams have quite a strained relationship. Whenever a member of the rapid response team rings up David feels defensive and apologetic even though he personally has done nothing wrong. When a district nurse rings about a client, David decides to ask whether there is any feeling among the district nurses that social services aren't picking up work quickly enough. The nurse starts to talk about certain cases, some of which David also knows the rapid response team are involved with. David decides that he needs to go and meet with the rapid response team and contacts their team leader. They welcome the opportunity for a 'clear the air' talk.

Questions

1 What are your comments on David's action? Is he networking? Give reasons.
2 If David wanted to take his networking further, what should he do?

Just about any situation can be used as the basis for networking. David could involve both the district nurses and rapid response team in regular meetings. Meeting together could help to foster a better understanding of each other's roles, work pressures and organisational cultures. This in turn could promote trust and facilitate problem solving. The network can also be enlarged, as other interested parties such as GPs and home care providers might have some useful input. The case study illustrates that by dealing with the problem directly, being proactive and making personal contacts you can increase the chances of making collaborative working run more smoothly.

Promoting collaborative working

In social care work there are several formal methods which bring different workers together to discuss cases and wider practice issues. Some common methods are now discussed below.

Case conferences/meetings

Case conferences are used widely in all aspects of social work and health and social care. In certain contexts, case conferences have a clearly laid down name, purpose and set of procedures that govern them. An example of this type of case conference would be the Initial Child Protection case conference. Official guidance covers all aspects of such a conference: when it should be called, who should be invited, what agenda should be followed and so on. However, in other settings the term is used in a very general way to mean a gathering of relevant workers involved in a case coming together to discuss details of the case. In the spirit of fostering user involvement, it is expected that the client, their carer and/or any other representative or advocate will be invited to attend part or all of the conference. Therefore, as a worker, if you felt that a case would benefit from a formally constituted meeting of those involved, you must invite the service user or their representatives. If you do not, you should have a very good reason why this would not be appropriate.

ACTIVITY

Earlier (see page 223), we looked at the case of Danny and his lunchtime visits to the pub. Imagine you were the care manager; explain how you would organise a case meeting so that the various issues could be sorted out. Key decisions that you will need to make in such a case would include:

- Who to invite?
- Where to have the meeting?
- When to have the meeting?
- Who will chair the meeting?
- How will the agenda be settled?
- How to record the meeting?
- What accountability, if any, will there be in any decisions taken?

If your meeting is not a conference called as the result of official guidelines or procedures, but simply because a sharing of views and information would be a good idea, it might be better to drop the term 'conference' and call it a case meeting instead. This will stop people being confused about its status. Case meeting sounds slightly less formal and official than case conference. Nevertheless, if a case meeting is going to promote collaborative working it should still be conducted in a proper manner.

These questions raise several interesting issues for working collaboratively. The chairing and agenda setting inevitably raises questions of power, for example who decides what can be discussed; the recording question raises issues of confidentiality, for example will minutes be produced; how will they be disseminated and where will they be kept? Even thornier, could be the questions of how or, indeed, whether Danny is invited. Does he require an advocate? What about his parents? This raises further issues of accessibility and transport. All meetings have their own dynamics and this is where professional territorial disputes can emerge. This makes it all the more important to establish an agreed set of ground rules and to make sure that everybody observes them. Sending out a rationale and proposed agenda in advance to all parties should help settle the meeting down quicker than if the meeting is convened with a completely open agenda.

Meetings must be planned in advance and the time used effectively

These are some of the issues that practitioners must be aware of when thinking about calling case meetings. The last point to make is that just having a meeting is not necessarily a sign of working collaboratively. We have all been to meetings that have descended into a free-for-all or have merely been an excuse to let off steam. Some people are expert at sabotaging or hijacking meetings. Therefore, for a case meeting to be an effective collaborative working tool we need to think clearly about what we are hoping to achieve and how it will improve care; in short, what the meeting's aims and objectives are. No one likes their time being wasted through attending meetings that are not relevant or useful. We cannot simply call a meeting in the hope that answers to difficult questions will spontaneously appear. We need to express our views and ideas and be prepared to amend them if needs be.

Liaison meetings

Liaison meetings differ from case meetings in that they are not called to discuss a specific case but are regular meetings between workers from different agencies. The purpose of such meetings can vary but usually the overall aim is to improve links between agencies. There could be some case discussion but there might be other items on the agenda, such as one group explaining about a new service or procedure to the other. Key features of liaison meetings are information sharing, breaking down professional barriers and ensuring that the agencies work collaboratively to promote better care.

REFLECT

1. At your place of work are there any liaison meetings with other agencies or other workers?
2. If there are, explain how they are arranged, venues, timing and so on. How effective are they in promoting collaborative working? How would you like to see them improved?
3. Which other agencies or workers don't you have liaison meetings with? What would it take to set them up?

As with case meetings, participants need to have a sense that attending the meeting is worth their while.

Liaison meetings can sometimes become 'ritualistic' in that people meet just because they have the date in their diary. Signs that liaison meetings are not working effectively are usually when absenteeism increases, when meetings are often cancelled or postponed or when participants merely 'go through the motions' – covering old themes and topics. The shame is that when these meetings are originally set up it is probably with a great sense of purpose and commitment. Workers often cite work pressures or lack of time for withdrawing from liaison meetings but this is often because they no longer see the value of meeting.

If you see the signs that liaison meetings are flagging, this does not mean that they should be allowed to simply wither away. Every section of this chapter has provided arguments for working collaboratively. To retreat into isolation, however tempting, raises the chances of client care suffering.

How to revive the flagging liaison meeting

- Acknowledge the problem and renegotiate the terms for meeting – change the interval, venue, anything to bring a fresher feel to the meeting.
- Invite 'new blood' to the meetings. This can either be new members from the agencies or another agency altogether.
- Consider guest speakers for joint training purposes.
- Introduce treats such as cake or even more exotic fare.
- Invite senior managers from time to time. Let them see the initiatives you are undertaking; they can also hear first hand your joint concerns.
- Set yourself a project, for example develop a new joint system in some area of working. You could even write it up and get it published!

Joint visits

The joint visiting of clients is a very obvious sign of working collaboratively and can have benefits. However, it can also create problems, so this all needs a fuller discussion. The benefits of visiting a client together with another worker are many. For the client it means that they avoid the duplication of two separate visits and have the benefit of two sources of knowledge being available at the same time. Joint visiting improves the likelihood that everything the client says will be better remembered and recorded. One worker can also observe whilst the other conducts the interview. Workers are less likely to take shortcuts in the company of workers from other agencies, and they are also less likely to slip into a narrow service-led approach.

When it comes to broaching difficult or sensitive matters workers can be emboldened by the presence of a fellow worker. Consequently, important but difficult issues which may normally be minimised by the lone worker can get a fuller airing. During the visit, if one worker wants the other's opinion from their specialist perspective it can be offered straight away rather than waiting for a referral to take place and all the time that this may take. After the visit both workers will be in a position to compare their impressions and bounce ideas off each other because they will have both been there. The assessment will be all the more rounded as a consequence.

On the negative side, two people visiting might be overwhelming for an individual. They can be inhibited in participating fully if they are confronted by two strangers in their house. We should always seek permission to visit jointly because it can increase the feeling of invasion into someone's home, however well-meaning the 'invaders' are. Joint visiting obviously takes up twice as much worker time, so the addition of another worker needs to actually add something to the visit to make it cost-effective, they can't simply be 'there for the ride'.

Also, joint visiting won't be successful if the workers act out any differences of opinion in front of the client. Sometimes people deliberately try to play one worker off against the other often in an attempt to equalise the power difference. However, on occasions joint workers can be drawn into a competitive game with each other about who is the most helpful or who gets on best with the client. Never underestimate the powerful dynamics of the three-way meeting. If joint visits are to be successful, the visits must be:

- well planned
- on the basis of a shared philosophy of care
- consensual
- an effective use of two workers' time.

REFLECT

Identify a recent example from your practice where it would have been useful to have made a joint visit. Explain clearly what the advantages would be and explain any possible disadvantages.

Joint training

Joint training can mean different things. It can mean workers from different agencies attending a course together on a particular topic; for example 'Managing Risk with Frail Older People'. In this type of event it could be that issues are being raised and messages given to a range of people from different professional backgrounds. In other words, the audience is a 'joint' audience. However, the trainers might be coming from a single perspective, for example physiotherapy. Alternatively, the trainers themselves could be from different perspectives (joint trainers) and the audience from one professional background.

It could be that the training is both jointly organised and jointly attended. In colleges and universities there are often modules which can be shared between students on different professional pathways. For example, health professionals and social work students may come together for a module entitled 'Policies and Practices for Community Care', but go their separate ways for other parts of their qualification. Joint training opportunities have been institutionalised in areas like child protection – all events are multi-disciplinary – but this is less the case in adult social care. Joint training can be a positive step towards effective collaborative working not only because of the knowledge and skills gained from the training, but also because of the opportunities for different workers from different backgrounds to meet informally, share experiences and generally get to know each other as people. Such opportunities must be approached with an open mind, because professional rivalries and mistrust can easily be brought into the training situation. This diminishes the whole experience if joint training only serves to reinforce stereotypes and confirm prejudices.

ACTIVITY

Find an opportunity to participate in joint training relevant to your job. Look on staff notice boards, newsletters, the Internet or ask your training officer. You need to identify a training event that will enable you to mix with workers from different backgrounds. Use the opportunity in a positive way to understand others' roles and responsibilities, how they work and make contacts for further reference. Be positive about what your agency contributes.

Work shadowing

In many people's minds, work shadowing tends be associated with new and inexperienced workers accompanying a more experienced worker in order to learn the job. This is a useful technique to help inexperienced workers to learn, but there are other possibilities for work shadowing that contribute towards working collaboratively.

Work shadowing is useful in itself, and it need not simply be seen as an activity for new workers. It is an excellent way of learning about other job roles, organisational cultures and how other agencies operate. All of this information is valuable in taking forward collaborative working. Therefore, we should seek to work shadow others and be receptive to others' request to work shadow us. To be done properly it needs to be set up with attention to detail. You need to be work shadowing someone over enough time to get a representative and valid picture of their work. You also need to consider the issue of permissions and the perennial social researcher's problem – what effect will your presence have on the person being shadowed? Finding sufficient time is always going to be an issue but it can genuinely be treated as staff development and will make the chances of collaborative working much more likely to happen and to be effective when it does.

KNOWLEDGE CHECK

1. Describe some of the activities which could be placed under the umbrella of 'networking'.
2. Give three reasons why networking helps promote collaborative working.
3. Explain two methods that promote collaborative working.
4. What responsibilities do managers have for ensuring effective partnership working?
5. What activities can teams participate in with other agencies to promote more liaison?

CASE STUDY

Improving choice and independence

Cumbria County Council

In Cumbria, we will work with our partners in health, the independent and voluntary sectors to ensure people have high-quality modern services which promote their independence and offer them real choice.

Context

- Cumbria has a significantly ageing population. By 2029 over 1 in 3 people will be of retirement age, a 69 per cent increase since 2004.
- Almost half of people aged over 65 rank health services as the most important factor in making somewhere a good place to live.
- Cumbria has pockets of poor health in areas of deprivation such as Barrow, west Cumbria and Carlisle.
- Just over 1 in 10 people in the county has a long-term illness or disability and of these three-quarters are not in employment.

Improved quality of life for older people and people with a disability in Cumbria

- Adult Social Care has provided an extra 10 people per 1000 population over 65 (mid-year 2006 65+ population estimate 2006 – 94,900)
- Adult Social Care provided support to an increasing number of older people. The number of those choosing to make use of the flexibility afforded by Direct Payments has risen

considerably from 94 at the end of September 2006 to 148 at the end of September 2007. There has also been substantial growth in the uptake of Direct Payments amongst people with learning disabilities and people with mental health problems, empowering them to have choice and control over their services.

- A 'Well read Scheme' set up between Adult Social Care, Cumbria Partnership Foundation NHS Trust and Cumbria Public Library Service has issued self-help material on more than 1,000 occasions to people experiencing mental health problems.
- During 2006/07, 91 per cent of equipment was delivered within seven days of an individual's need assessment, placing Cumbria's performance in this field in the top UK performance quartile.

Improved independence increases well-being through choice and control

- Cumbria Adult Social care is a leading Council in the national In Control Total pilot scheme for developing a system of self-directed support to enable people to exercise choice and control over the services they use to improve the quality of their lives. Over 600 people have an individual budget.
- The 'Prevention Works' programme has been developed with the Third Sector to support older people with long-term health conditions and assist in maintaining their independence as long as possible.

'What the County Council does and achieves as an organisation has to be set within its wider partnership context. Increasingly, the Council is playing a key role in shaping shared countywide objectives, coordinating shared resources and delivering shared outcomes to improve the [illegible] of life of residents and communities.

The Local Area Agreement is the delivery plan [illegible] a more strategic document, the Community Strategy for Cumbria. The Council (through [illegible] Cumbria Strategic Partnership) has led the [illegible] to develop both the Community Strategy and [illegible] Local Area Agreement.

The Third Sector is a key partner for the Council and Cumbria is fortunate in having a wide [illegible] enthusiastic and active voluntary organisations. The County Council is committed to supporting the sector to increase its capacity to engage [illegible] partnership working and help deliver excellent [illegible] innovative services to local communities and communities of interest.

The Council also works with a range of commercial partners to deliver specific services. This has contributed to efficiency savings for which the Council has been nationally recognised. Partners such as Amey, Capita and Agilisys are also instrumental in achieving the outcomes set out [illegible] this Plan.'

(www.cumbria.gov.uk, 2008)

Questions

1 How do you think that Local Area Agreements influence the strategic direction of care services in an area?
2 Cumbria mentions both public and private providers, do you think that this should always be the case? Do local areas need a balance of private/public partnerships?
3 What aspects of partnership do your local authority seem most proud of in their public documentation?

REFLECT

Identify a worker who you would like to shadow. Explain why you chose that particular worker. Think about what you expect to learn from that person and explain what steps you need to take to put into practice what you learn.

KNOWLEDGE CHECK

1 Make a list of four skills or ways of behaving that will facilitate collaborative working.
2 In your own words, explain what it is to be assertive.
3 Explain why it helps to be assertive if working collaboratively.
4 Have you got a clear sense of your job role? Briefly explain what it is. What are your specialisms?
5 Give examples of the negative effects of poor negotiating skills.
6 Identify six pointers from the successful negotiation checklist.
7 Describe some of the activities which could be placed under the umbrella of 'networking'.
8 Give three reasons why networking helps promote collaborative working.
9 Explain two methods that promote collaborative working.
10 What questions does a worker need to consider when deciding to call a case conference?
11 What is the difference between a case meeting and a liaison meeting?
12 Describe two advantages and two disadvantages of joint visiting.
13 What factors will ensure that joint visits are successful?
14 Explain how work shadowing can help with collaborative working.

Glossary

Commissioning: the process of finding organisations to deliver services, by advertising, testing suitability and securing a contract.

Competition: where organisations are judged about their suitability to provide a service in comparison to other agencies.

Contestability: the process of considering different providers, with the potential for changing providers.

Integration: the joining of organisations for the delivery of services.

Governance: strategic management of an organisation: the systems and processes concerned with ensuring the overall direction, effectiveness, supervision and accountability of an organisation.

Pooled commissioning budgets: where organisations put their separate monies into a single pot in order to focus on delivering an aspect of a service together.

Social enterprise: profit-making business set up to tackle a social or environmental need.

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